

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: BALTIMORE  
 County.....  
 City or town..... WOODSTOCK  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 44 yrs.  
 Hospital, institution, or street address where death occurred:  
WOODSTOCK COLLEGE  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... MD..... County..... BALTO  
 City or town..... WOODSTOCK  
 (if outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME BROTHER CHARLES ABRAM 3. (b) Social Security Number .....

4. Sex MALE 5. Color or race WHITE 6. (a) Single, married, widowed, or divorced SINGLE  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.) APRIL 1<sup>st</sup> 1885  
 8. AGE: Years 63 Months 2 Days 24 It less than one day ..... hrs. .... min.

9. Birthplace AUSTRIA  
 (Town, county, and state)  
 10. Usual occupation RELIGIOUS - BROTHER  
 11. Industry or business.....  
 12. Name UNKNOWN  
 13. Birthplace.....  
 14. Maiden name.....  
 15. Birthplace.....

16. Informant COLLEGE RECORDS  
 Address WOODSTOCK MD  
 17. BURIAL Date thereof JUNE 25 48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory WOODSTOCK COLLEGE CEM  
 Location WOODSTOCK MD

18. Funeral director Bernard C. Harle  
 Address 121 E. West St. Baltimore

19. June 25 1948 a. w. Hedrick  
 (Date filed by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 24 1948, at 1007 A M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1944 to June 24 1948  
 and that I last saw him alive on June 17 1948  
 Immediate cause of death Coronary thrombosis  
 Due to Hypertension  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

## DURATION

3 hrs

Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?

23. SIGNATURE Harold H. Burns M. D. or other  
 Address 529 N. Charles St Date signed 6/25/48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 yrs  
Hospital, institution, or street address where death occurred:

How long in hospital or institution? 3 yrs

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 6401 Old Harford Rd  
(If rural, give LOCATION)  
2. (a) If veteran, name war

### 3. (a) FULL NAME

Mrs Elizabeth Katherine Aharon

### 3. (b) Social Security Number

4. Sex Female 5. Color of race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Edward Taylor Aharon  
7. Birth date of deceased (mo., day, yr.) Jan. 25 - 1868  
6. (c) If alive, give age years

8. AGE: Years 80 Months 5 Days 5 It less than one day  
hrs. min.

9. Birthplace Lakenville, Dorchester Co., Md  
(Town, county, and state)

10. Usual occupation Dressmaker

11. Industry or business

12. Name Wm. H. Insley

13. Birthplace Lakenville, Dorchester Co. Md

14. Maiden name Catherine Stewart

15. Birthplace Dorchester Co.

16. Informant Anna M. Schneider

Address Cockeysville Md

17. Burial Date thereof July - 3 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Baltimore Cemetery

Location Baltimore

18. Funeral director Wm. Cook

Address St. Paul & Preston St

19. July 1<sup>st</sup> 19 48 J. M. Schneider  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 48 at 12<sup>15</sup> noon

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 47 to June 30 19 48  
and that I last saw her alive on June 30 19 48

Immediate cause of death Cardiac Decompensation DURATION 1 day

Due to Cardiac Hypertrophy 5 yrd  
Due to Arterial Sclerosis 6 yrs  
Other conditions Sclerosis

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Kees M.D.

Address Cockeysville Md Date signed 6/30/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUL 2 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5861

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

1. PLACE OF DEATH: Baltimore  
County Bradschaw  
City or town 4 yrs  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Bradschaw  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 40  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3. (a) FULL NAME John E. Albers

3. (b) Social Security Number

4. Sex M. 5. Color or race W. 6. (a) Single, married, widowed, or divorced Widowed  
6. (b) Name of husband or wife Marie K. Albers  
7. Birth date of deceased (mo., day, yr.) Jan 6 - 1872  
8. AGE: Years 76 Months 6 Days 24 If less than one day  
hrs. min.

9. Birthplace Germany  
(Town, county, and state)  
10. Usual occupation  
11. Industry or business

12. Name Albers  
13. Birthplace Germany  
14. Maiden name Unknown  
15. Birthplace Maryland

16. Informant Mrs. C. E. Newcomer  
Address Bradschaw Md.

17. Burial Date thereof 7 3 48  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Lorraine  
Location Baltimore

18. Funeral director Philip Herwig Sons  
Address 2024 Orleans St

19. July 2 19 48 Regd. Medical  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 19 48 12:45 P.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 47 to June 30 19 48  
and that I last saw him alive on June 29 19 48

Immediate cause of death Cerebral Thrombosis DURATION 3 da.

Due to Coronary Sclerotic 1 yr.  
Heart Disease  
Due to Diabetes Mellitus 5 yrs.

Other conditions  
(Include pregnancy within 3 months of death)

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Clifford F. Hudson M.D. M. D. or other  
Fork, Md. Date signed 7/1/48

MARGIN RESERVED FOR BINDING

1

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5862

XX

## 1. PLACE OF DEATH

County Balto.  
 City or town Middle River  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Martinez Air Plant.

How long in hospital or institution?

9 yrs.

## 3. (a) FULL NAME

Robert L. Anthony

## 3. (b) Social Security Number

## 4. Sex

Male white

## 5. Color or race

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Florence

## 7. Birth date of

deceased (mo., day, yr.)

June 11, 1907

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

41017

hrs.

min.

## 9. Birthplace

Md.

(Town, county, and state)

## 10. Usual occupation

Machinist

## 11. Industry or business

Glenn J. Martin

## FATHER

## 12. Name

Robert L. Anthony

## 13. Birthplace

Md.

## MOTHER

## 14. Maiden name

Jennie Roe

## 15. Birthplace

Md.

## 16. Informant

Robert L. Anthony

## Address

816 S. Rose St.

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

7/1/48

## Cemetery or crematory

St. Olives

## Location

Frederick Ave

## 18. Funeral director

Fuller & Zickel

## Address

403 W. 1st St.

## 19.

(Date rec'd by registrar)

19

6/25XXAsst. Medical

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

## State

## County

## City or town

Baltimore

(If outside city or town limits, write RURAL and give nearest town)

## Street No.

816 S. Rose St.

(If rural, give LOCATION)

## 2. (a) If veteran, name war

✓

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 28, 1948, at 8:08 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him..... alive on 19.....

## Immediate cause of death

## DURATION

Coronary occlusion

## Due to

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Imberson M.D.

M.D. or other

## Address

Baltimore, Md.

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5863

Reg. Dist. No. 4X

## 1. PLACE OF DEATH:

County BALTIMORE  
 City or town SPARROWS PT  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

12 STAFFORD AVE  
(EDGEHURST)

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BALTIMORE  
 City or town SPARROWS PT. (EDGEHURST)  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 12 STAFFORD AVE  
 (If rural, give LOCATION)

2.(a) If veteran, name war WW I

## 3. (a) FULL NAME

ELLSWORTH HURD ARMSTRONG

## 3. (b) Social Security Number

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

OCT 21, 1890

6.(c) If alive, give age ..... years

8. AGE:

Years

Months

Days

If less than one day

57

hrs.

min.

9. Birthplace

BALTIMORE, MD.  
(Town, county, and state)

10. Usual occupation

- NONE

11. Industry or business

II

FATHER

12. Name

WILLIAM J. ARMSTRONG

13. Birthplace

BALTIMORE, MD

MOTHER

14. Maiden name

CORA E. MARBETT

15. Birthplace

BALTIMORE, MD.

16. Informant

MRS CORA ESTHER WHITE

Address

2401. SPARROWS PT. RD.

17.

BURIAL  
(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

6/5/48

Cemetery or crematory

BALTIMORE NATIONAL

Location

FREDERICK ROAD

18. Funeral director

JOHN F. DENNY, INC.

Address

715 LIGHT ST -30

19.

6-4  
(Date rec'd by registrar)

19

48August1948

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 2 19 48 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death

1. Alcoholism - Acute  
2. Coronary Occlusion

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide homicide Date ofWhere did injury occur? home (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. James B. Davis (M.D. or other)  
James B. Davis Address Date signed 6/4/48

Mr. Wain

3 Kinship Rd.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Garrison  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Matthew S. Atkinson, Jr.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Jennie P.6. (c) If alive, give age 54 years7. Birth date of deceased (mo., day, yr.) Oct 15, 1880

## 8. AGE:

Years

67

Months

7

Days

10

If less than one day

.....hrs. ....min.

9. Birthplace Baltimore, Md.

(Town, county, and state)

## 10. Usual occupation

Insurance

## 11. Industry or business

12. Name Matthew S. Atkinson13. Birthplace Baltimore, Md.14. Maternal name Eliza Blou15. Birthplace Virginia16. Informant Jennie Price AtkinsonAddress Garrison, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 6 - 27 - 48  
(month) (day) (year)Cemetery or crematory St. ThomasLocation Garrison Forrest18. Funeral director Frank H. NewellAddress Pikesville, Md.19. 6 - 26 - 48

(Date rec'd by registrar)

E. E. Nichols Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Garrison, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war .....

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25, 19 48 at 3-AM M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 29, 19 46 to June 25, 19 48and that I last saw him alive on June 21, 19 48

## Immediate cause of death

Coronary Occlusion

## DURATION

SuddenDue to Coronary Artery Disease1-yr 8-MosDue to Chronic Myocarditis?

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ....

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? .....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE E. E. Nichols M. D. or otherAddress Pikesville-8, Md. Date signed 6/26/48

RECEIVED  
JUN 29 1948  
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 30

## 1. PLACE OF DEATH:

County Baltimore CountyCity or town Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 17 days

Hospital, institution, or street address where death occurred:

Hasler's LodgeHow long in hospital or institution? 17 days

## 3. (a) FULL NAME

Carrie H. Angur

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) Jan. 5, 1875

8. AGE: Years Months Days If less than one day

73 hrs. min.9. Birthplace San Antonio, Texas  
(Town, county, and state)10. Usual occupation Social worker11. Industry or business Welfare12. Name Jacob A. Angur13. Birthplace New York14. Maiden name Katherine Dodge15. Birthplace Washington D.C.16. Informant Sister - Mrs. Clara WilsonAddress 2715 Q St. N.W. Wash. D.C.17. Removal Date thereof June 11, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematorium Washington Nat'l CemLocation St. Paul, Virginia18. Funeral director Joe. Garofalo Sons Inc.Address 1750 Pennsylvania Ave. Wash. D.C.19. June 11, 1948 V.E. Harris  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.City or town D.C.  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2025 N. St. N.W. Wash. D.C.  
(If rural, give LOCATION)2. (a) If veteran, name war ✓

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 1948 at 10:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/23, 1948 to 6/10, 1948and that I last saw him alive on 6/10, 1948Immediate cause of death Cancer - StomachDURATION 1 yr. +

Due to.....

Due to.....

Other conditions Generalized arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. V. Williamson M.D.Address Hasler's Lodge Date signed 6/10/48Balto. 20, Md.



RECEIVED

JUN 14 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age shown on: 2nd change  
 FILM No. G 116 JUL 2 1948  
 MARYLAND STATE DEPARTMENT OF HEALTH  
 2411 N. Charles St., Baltimore

93d

5866

FILM No. G 116 JUL 2 1948

Items 20, 21: statement of

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

Dr. S. filled 6-11-48 (on CC #8666 Gr. 48)

## 1. PLACE OF DEATH:

County: Baltimore  
 City or town: Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Greenspring Ave. & Ridge Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: md. County: Baltimore  
 City or town: Owings Mills  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.: Greenspring Ave. & Ridge Road  
 (If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

James W. Baker

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

Margaret J. Baker

7. Birth date of

deceased (mo., day, yr.)

October 8, 1857

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

90 91 91816

hrs.

min.

9. Birthplace

Harrisville, Pa.

(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

6-25-48

Mary B. Elime

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

6-25-48

at

11:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov. 11-11-48 to 6-25-48  
 and that I last saw him alive on 6-24-48

Immediate cause of death

Myocarditis  
chronic  
or thrombosis

Due to

Due to

Other conditions

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 6-25-48

RECEIVED

JUN 29 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 4867

1. PLACE OF DEATH:  
 County... 136 Carnival Rd  
 City or town... Balto. Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Md County... Turners Station  
 City or town... Balto  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 136 Carnival Rd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

3. (a) FULL NAME  
Carrie Barnhill

3. (b) Social Security Number

4. Sex F 5. Color or race C 6.(a) Single, married, widowed, or divorced W

6.(b) Name of husband or wife Zeno

7. Birth date of deceased (mo., day, yr.) 9-1886 6.(c) If alive, give age... years

8. AGE: Years 61 Months Days It less than one day hrs. min.

9. Birthplace Greenville, N.C.  
 (Town, county, and state)

10. Usual occupation domestic

11. Industry or business

FATHER 12. Name Red Brady  
 13. Birthplace N.C.

MOTHER 14. Maiden name Julia  
 15. Birthplace N.C.

16. Informant Indentaker Flannagan  
 Address Greenville, N.C.

17. Burial Date thereof 6/10/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Greenville  
 Location Greenville, N.C.

18. Funeral director Mrs. S. Nelson  
 Address 1303 Presstman St

19. 6/9 48 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION  
 20. DATE OF DEATH June 9 19 48 at 3:40 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 19 48 to May 9 19 48  
 end that I last saw her alive on May 9 19 48

Immediate cause of death Hypertensive Heart Disease DURATION 2yr.

Due to  
 Due to

Other conditions  
 (Include pregnancy within 3 months of death)

Major findings of operations  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE William S. Nicks, M.D. M. D. or other  
 Address 140 Oak Ave Date signed 6-9-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5868

30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Adm: 8-21-47  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? Adm: 8-21-47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County City  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3319 Virginia Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war..... ✓

## 3.(a) FULL NAME

Louise Bateman

## 3.(b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Harry Bateman - deceased  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) July 21, 1870  
 8. AGE: Years 77 Months 8 Days 20 If less than one day  
 .....hrs. ....min.

9. Birthplace Portchester, New York  
 (Town, county, and state)  
 10. Usual occupation Practical nursing  
 11. Industry or business  
 MOTHER FATHER  
 12. Name George Day  
 13. Birthplace New York  
 14. Maiden name Unknown (first name Oliver)  
 15. Birthplace

16. Informant Mrs. Alvah Childs  
 Address 7745 Garrison Rd. Hyattsville, Md.  
 17. Burial Date thereof 6/14/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Parkwood  
 Location Parkville Md  
 18. Funeral director William Cook Inc.  
 Address 1217 St. Paul St.  
 19. 6-14-48 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 48 at 7. p M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
8-21-47 to 6-11-48  
 and that I last saw him..... alive on.....  
 Immediate cause of death Bronchial Pneumonia

DURATION  
6 days

1. Collorary Heart Disease  
 Due to.....  
 2. Arteriosclerosis Heart Dis  
 Due to.....  
 3. Generalized arteriosclerosis  
 Due to.....  
 heart dis.

Indef.

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?.....  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE.....  
 Address..... Date signed.....  
 M. D. or other

Dr. I. Tuerk

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County BaltimoreCity or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 Yr.

Hospital, institution, or street address where death occurred:

36 Linganore Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Parkville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 36 Linganore

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Bertha Mae Baublitz

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife William J.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Oct. 19 18848. AGE: Years Months Days If less than one day  
63 8 7 hrs. min.9. Birthplace Fork, Md.  
(Town, county, and state)10. Usual occupation Houswewife

11. Industry or business

12. Name David Carter13. Birthplace Baltimore, Co. Md.14. Maiden name Margaret Crue15. Birthplace Baltimore, Co. Md.16. Informant Mrs. Evelyn RigginsAddress 36 Linganore Ave17. Burial Date thereof June 29 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fork MethodistLocation Fork Md.18. Funeral director William J. Tickner & SonsAddress North & Pennsylvania Aves19. 6/2 X W. Hedrick  
(Date rec'd by registrar) (Date) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 19 48 at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6/1/48 19 48 to 6/26/48 19 48and that I last saw him alive on 6/26/48 19 48Immediate cause of death StrokeMyocarditis

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Hedrick M. D. or otherAddress 5703 Hartford Date signed 6/2/48

MARGIN RESERVED FOR BINDING

I

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The carriage is especially important. Physicians: please write the causes of death clearly and legibly.



Styke Gully  
5103 Hayford Rd

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH: Balto.  
County.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?.....  
Hospital, institution, or street address where death occurred:.....  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State.....  
City or town.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME.....  
3. (b) Social Security Number.....

4. Sex.....  
5. Color or race.....  
6.(a) Single, married, widowed, or divorced.....  
6.(b) Name of husband or wife.....  
6.(c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.).....  
8. AGE: Years..... Months..... Days..... If less than one day..... hrs. .... min.

9. Birthplace.....  
(Town, county, and state)  
10. Usual occupation.....  
11. Industry or business.....  
12. Name.....  
13. Birthplace.....  
14. Maiden name.....  
15. Birthplace.....

16. Informant.....  
Address.....  
17. Burial, cremation, or removal, which?..... Date thereof..... (month) (day) (year)  
Cemetery or crematory.....  
Location.....  
18. Funeral director.....  
Address.....  
19. (Date rec'd by registrar).....

MEDICAL CERTIFICATION  
20. DATE OF DEATH.....  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... to..... and that I last saw him/her alive on.....  
Immediate cause of death.....  
DURATION.....  
Due to.....  
Due to.....  
Other conditions.....  
(Include pregnancy within 3 months of death)

Major Findings of operations.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.  
22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town)..... (County)..... (State).....  
Injured at home, farm, industry, public place (where?).....  
Means of injury..... Injured at work?.....

SIGNATURE.....  
Address.....  
Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

### 1. PLACE OF DEATH

County Baltimore  
City or town Ringville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Harford County Harford  
City or town Aberdeen Md.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.   
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Charles Richard Brickham

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife Laral Brickham

7. Birth date of deceased (mo., day, yr.) Mar. 17<sup>th</sup>, 1896

8. AGE: Years 82 Months  Days  If less than one day  hrs.  min.

9. Birthplace South Mountains  
(Town, county, and state)

10. Usual occupation Blacksmith

11. Industry or business

12. Name Martin Brickham

13. Birthplace Pa.

14. Maiden name Cynthia Brickham

15. Birthplace Pa.

16. Informant Charles A. Brickham

Address Aberdeen R.F.D. 1

17. burial Date thereof June 9, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Dallas, Pa.

Location Lassak Funeral Home

18. Funeral director 7401 Belair Rd.

Address

19. June 7 19 48 Drs. J. L. Reifman  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 at 10:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from None 19  to 19

and that I last saw him None alive on 19

Immediate cause of death Multiple fractures: Spine DURATION 6/5/48  
curial & lumbar; skull. Sudden

Due to Auto accident - struck by car 6/5/48

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident suicide, or homicide Auto Date of 6/5/48

Where did injury occur? Ringville Baltimore Md  
(City or town) (County) (State)

Injured at home farm, industry, public place (where?) Rt. 1 Highway

Means of injury Struck by auto Injured at work? no

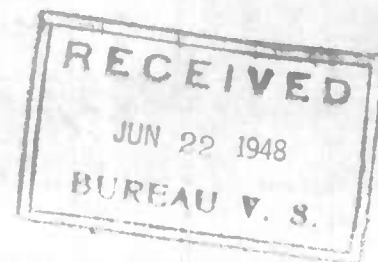
23. SIGNATURE Rollin C. Hudson M.D. D.M.E.

Address Towson 4 Md Date signed 6/5/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

5872

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard,  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 57 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 57 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1841 Iorman Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I ✓

## 3. (a) FULL NAME

JAMES H. BLOUNT

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Eva Blount7. Birth date of deceased (mo., day, yr.) 9-30-936. (c) If alive, give age 47 years

## 8. AGE:

Years

Months

Days

If less than one day

54824

hrs.

min.

9. Birthplace Greenville, N. C.  
(Town, county, and state)10. Usual occupation Unemployed

## 11. Industry or business

FATHER

12. Name Mary King  
13. Birthplace North Carolina

MOTHER

14. Maiden name Edmond Blount  
15. Birthplace North Carolina16. Informant Clinical Records, Vets. Adm. H. sp.  
Address Fort Howard, Maryland17. Burial 6/29/48  
(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)Cemetery or crematory Baltimore National Cemetery  
Baltimore, Md.Location Adolphus Halstead18. Funeral director Druid Hill Ave., Balto., Md.  
Address19. 6/25 48 R. W. Holmes  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 24, 19 48 at 9:12 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 28, 19 48 to June 24, 19 48  
and that I last saw him alive on June 24, 19 48

Immediate cause of death

Cerebral Infarcts

DURATION

Unknown

Due to

Due to

Other conditions Hypertrophy of left ventricle  
due to Hypertension & chr. Nephritis 15  
(Include pregnancy within 3 months of death) Yrs.

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. C. Manauagh  
H.C. MANAUGH, M.C. Chief Prob. Ser.Address VAH, Ft. Howard, Md. Date signed 6-24-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH

County BaltimoreCity or town Boring - Rural  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Boring - Rural  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Burley W Boring

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6. (a) Single, married, widowed, or divorced

m.6. (b) Name of husband or wife Sallie Price Boring6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) Jan 1 - 1872

8. AGE: Years Months Days If less than one day

76512

hrs.

min.

9. Birthplace md  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Greenbunay Boring13. Birthplace md14. Maiden name Unknown15. Birthplace "16. Informant Mrs Burley BoringAddress Boring md17. Burial Date thereof June 17/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Louise RidgeLocation Balto md18. Funeral director Edw E. EptonAddress Hampstead Md19. 6-16-1948 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 13 19 48 at 6:30 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

December 21 19 47 to June 13 19 48and that I last saw him alive on June 12 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic Myocarditis?Due to Arteriosclerotic Cardio VascularDue to Disease

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Edgar M. Boring MD  
M. D. or other \_\_\_\_\_Address Hampstead Md Date signed 6-13-48



RECEIVED

JUN 23 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 40

5874

93d

### 1. PLACE OF DEATH:

County Balto.  
City or town Glenarm  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 17 years  
Hospital, institution, or street address where death occurred:  
Simms Ave.  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.  
City or town Glenarm  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Simms Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

WALTER E. BOTELER

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Carried E. Boteler  
6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 23, 1866

8. AGE: Years 81 Months 11 Days 2 If less than one day  
hrs. min.

9. Birthplace Howard Co., Md.  
(Town, county, and state)

10. Usual occupation Carpenter

11. Industry or business retired

12. Name Unknown

13. Birthplace Unknown

14. Maiden name Josephine Elliason

15. Birthplace Unknown

16. Informant Mr. Frank M. Luskorn

Address Simms Ave., Glenarm, Md.

17. burial Date thereof June 28, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Loudon Park

Location Balto., Md.

18. Funeral director Lansdown Funeral Home

Address 7401 Belair Road

19. June 24, 1948 W. M. Hammett  
(Date rec'd by registrar) (Signature) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 25th, 19 48 at 10:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan. 16 19 40 to June 25 19 48  
and that I last saw him alive on June 25 19 48

Immediate cause of death Chronic myocarditis  
Hypertension

DUE TO

DUE TO

Other conditions Gastro-enteritis

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

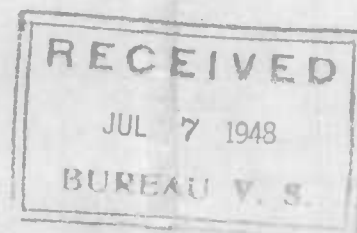
23. SIGNATURE A. M. Bacon M.D.

Address 2810 Taylor Ave. Date signed 6/25/48

MARGIN RESERVED FOR BINDING

VS A15 9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUL 7 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 460

5875

449

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 31 Days

Hospital, institution, or street address where death occurred:

V.A.H. Fort Howard, Md.How long in hospital or institution? 31 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 153 W. Lanvale St.  
(If rural, give LOCATION)2.(a) If veteran, name war SAW ✓

## 3.(a) FULL NAME

CARTER L. BOWIE

## 3.(b) Social Security Number

218-05-0802

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male White Single

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 22, 18728. AGE: Years 75 Months 10 Days 29 If less than one day  
hrs. min.9. Birthplace Prince George Co., Md.  
(Town, county, and state)10. Usual occupation None

11. Industry or business

12. Name Oden Bowie13. Birthplace Maryland14. Maiden name Alice Carter15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial Date thereof 6/24/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fairview P.O. Mitchellville,Prince George Co., MarylandLocation Bureau of Light18. Funeral director Howard BlightAddress 4914 Belair Rd., Balto., Md.19. 6/24/48  
(Date rec'd by registrar)Dr. H. C. Managh  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 19 48 at 6:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 21 19 48 to June 21 19 48and that I last saw him alive on June 21 19 48Immediate cause of death  
Carcinoma of the esophagusDURATION  
6 Months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H. C. ManaghH.C. MANAGH, M.D. Chief Prob. ServicesAddress VAH, Ft. Howard, Md. Date signed 6-22-48

-BALTIMORE CITY HEALTH DEPARTMENT  
**CERTIFICATE OF DEATH**

Registered No.

30

1. PLACE OF DEATH:  
 (a) Baltimore City, Maryland *Catonsville*  
 (b) Street address ~~1111 1st St~~  
 (c) Hospital or institution: *Spring Grove Hosp.*  
 (d) Length of stay in hospital or inst. (yrs., mos., or days) *4 yr. 2 mo.*  
 (e) Length of stay in Baltimore (yrs., mos., or days) *4*

2. USUAL RESIDENCE OF DECEASED:  
 (a) State *MD.* (b) County *Baitu.*  
 (c) City or town *Owings Mills*  
 (If outside city or town limits, write RURAL and give town)  
 (d) Street No. *Ward's Chapel Rd.*  
 (If rural give location)  
 (e) Citizen of foreign country? \_\_\_\_\_ (Yes or No)  
 If yes, name country \_\_\_\_\_

3 (a) FULL NAME *BERNARD (Ernest Joseph) BRADY*

3 (b) If veteran, name war *NO* 3 (c) Social Security Account No. *None*

4. Sex *M* 5. Color or race *W* 6 (a) Single, married, widowed, or divorced.

6 (b) Name of husband or wife \_\_\_\_\_ 6 (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) *8-20-1923*

8. AGE: Years *24* Months *10* Days *1* If less than one day \_\_\_\_\_ hr. \_\_\_\_\_ min.

9. Birthplace *MD.* (Town, county, and state)

10. Usual Occupation *None*

11. Industry or business \_\_\_\_\_

12. Name *Wm Brady*

13. Birthplace *MD.*

14. Maiden Name *Mary K. Hugel*

15. Birthplace *MD.*

16 (a) Informant *Wm Brady*

(b) Address *Owings Mills Md*

17 (a) *Burial* (b) Date thereof *6/22/48*  
 (Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory *Holy Family*  
 Location *Catonsville Md*

18 (a) Funeral director *Frank J. Merrill*

(b) Address *Pikesville Md*

19 (a) *June 22, 1948* (b) *A. W. Hirsch*  
 (Date rec'd by registrar) (Signature) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH *June 21, 1948* at *1:30* A.M.

21. I certify that I took charge of the remains described above, held an *Autopsy* thereon and from the evidence obtained Autopsy, Inspection or Inquiry by said Autopsy, Inspection or Inquiry, find that said deceased came to *his* death on the day stated above, and death in my opinion resulted from: natural causes ☒ accident ☐ suicide ☐ homicide ☐ undetermined ☐ and that the causes of death were:

**IMMEDIATE CAUSE OF DEATH**

*Acute pulmonary edema*

Due to *Acute congestive cardiac failure*

Other Conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

22. If an external cause was primary ☐ or contributing ☐ cause of death, fill in the following:

(a) Date of injury \_\_\_\_\_ at \_\_\_\_\_ M.

(b) Where did injury occur? \_\_\_\_\_

(c) Did injury occur at home, on farm, industrial place, in public place? \_\_\_\_\_ While at work? \_\_\_\_\_

(d) Means of injury \_\_\_\_\_

23. Signature *George G. Merrill* M.D.

Date signed *6/21/48* Medical Examiner.

MARGIN RESERVED FOR BINDING

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. XX

5877

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 92 Days  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution? 92 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1530 Argyle Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war WWII

## 3. (a) FULL NAME

CHARLES H. BROWN

## 3. (b) Social Security Number

unknown

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov. 12, 1918  
 8. AGE: Years 29 Months 7 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Clarksville, Georgia  
(Town, county, and state)10. Usual occupation Wholesale

11. Industry or business

12. Name Harry Brown13. Birthplace Unknown14. Maiden name Florence ????15. Birthplace Virginia16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Md.17. Removal Date thereof June 13, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Deep Creek CemeteryLocation Clarksville, Ga.18. Funeral director Charles R. LawAddress 802 Madison Ave. Baltimore, Md.19. 6/18 XP RAJ Hedrick  
(Date rec'd by registrar) \_\_\_\_\_ Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1948, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
March 12 1948 to June 12 1948  
 and that I last saw him alive on June 12 1948

Immediate cause of death  
MILIARY TUBERCULOSIS, ACUTE

DURATION

3 Mos.  
Plus

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Milton Ginsberg

Milton Ginsberg, M.D.

M. D. or other

Address VAH, Fort Howard, Md. Date signed 6/13/47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County..... Baltimore - 14.

City or town..... Fort. Howard.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?..... 2 1/2 yrs.

Hospital, institution or street address where death occurred..... Denton Ave.

How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn Infants give residence of mother)

State..... County.....

City or town..... As in #1.  
(If outside city or town limits, write RURAL and give nearest town)

Street No.....  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

### 3. (a) FULL NAME

FREDERICK WILLIAM MARTIN BURHEISTER.

### 3. (b) Social Security Number

None.

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

Widowed.

6. (b) Name of husband or wife..... ANNA BURHEISTER.

7. Birth date of deceased (mo., day, yr.)..... may 4. 1872

8. AGE: Years..... 46. Months..... 1 Days..... 18 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Md.  
(Town, county, and state)

10. Usual occupation..... Carpenter.

11. Industry or business..... Building industry.

12. Name..... Frederick Burmeister.

13. Birthplace..... Germany.

14. Maiden name..... Anna. Fox.

15. Birthplace..... Germany.

16. Informant..... Kenneth Lavery.

Address..... As in #1.

17. Burial (Burial, cremation, or removal, Which?) Date thereof..... June 26/48  
(month) (day) (year)

Cemetery or crematory..... Meadow Ridge

Location..... Wash. Blvd

18. Funeral director..... William Sunl Home

Address..... 2008 Orleans St.

19. 6/28 19 48 John Hedrick  
(Date rec'd by registrar) (Registral)

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 22 48 at 12:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48 to June 22 48 and that I last saw him alive on June 20 48

Immediate cause of death..... myocardial failure. DURATION..... sudden

Due to..... Hypertension

Due to..... Coronary Vascular Disease

Other conditions..... Senility.

(Include pregnancy within 8 months of death)

Major findings of operations..... none.

Autopsy results..... none.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury..... Injured at work?

Signature..... Louis N. Tallini M.D.

23. SIGNATURE..... 908 N. P. Rd. Balt. 19. M. D. or other

Address..... Date signed..... 6/22/48

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

64416

hrs

min.

9. Birthplace

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

18.

19.

19.

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 20 June 1948 at 6:40 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

8 February 1948 to 20 June 1948and that I last saw deceased alive on 19 June 1948

Immediate cause of death

Concussion of body of uterus with metastases

DURATION

1 yr +

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Inoperable carcinoma of body of uterus Date of op. July 1947

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

M. D. or other

Address

Date signed 21 June 1948

RECEIVED

JUN 24 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Towson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Since May 7, 1926  
 Hospital, institution, or street address where death occurred:  
Sheppard & Enoch Pratt Hospital  
 How long in hospital or institution? Since May 7, 1926

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Talbot  
 City or town..... Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Goldsborough Ch-  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war..... No ✓

## 3. (a) FULL NAME

CHAMBERLAINE, Miss Bertha M.

## 3. (b) Social Security Number

4. Sex..... Female 5. Color or race..... White 6. (a) Single, married, widowed, or divorced..... Single  
 6. (b) Name of husband or wife.....  
 7. Birth date of deceased (mo., day, yr.)..... Unknown 6. (c) If alive, give age..... Abt. Sep-24-1857 years  
 8. AGE: Years..... 87 Months..... 6 Days..... 4 It less than one day..... hrs. min.

9. Birthplace..... Talbot County, Md.  
(Town, county, and state)10. Usual occupation..... None

11. Industry or business.....

FATHER 12. Name..... Samuel Chamberlaine  
 13. Birthplace..... Maryland

MOTHER 14. Maiden name..... Elizabeth Dickinson  
 15. Birthplace..... Maryland

16. Informant..... Hospital records and  
 Address..... (Miss Mary Trappe-10137 Charles-Balls)

17. Burial..... Burial Date thereof..... 6-30-48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory..... Springhill  
 Location..... Easton - Md

18. Funeral director..... Stewart-McCormick Co.  
 Address..... 108 W North Av. Balls.

19. June 29 19 48 2 20 Healy  
 (Date rec'd by registrar) (Time) (Day) (Month) (Year) (Signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 27 19 48 at 12:17 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 13 19 46 to June 28 19 48  
 and that I last saw him alive on June 28, 1948

Immediate cause of death..... Cerebral Hemorrhage DURATION..... 3 days

Due to.....

Due to.....

Other conditions..... Bronchopneumonia 2 days

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Harry H. Hurdock M. D. or otherAddress..... Sheppard-Pratt, Towson, Md. signed 6/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 5882

## 1. PLACE OF DEATH:

County BaltimoreCity or town Rural - Harbor View  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 yr

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Rural - Harbor View  
(If outside city or town limits, write RURAL and give nearest town)Street No. 521 46th Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

JOHN MARTIN CHODZINSKI

## 3. (b) Social Security Number

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male

White

Widowed

6.(b) Name of husband or wife Frances

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) March 17, 18758. AGE: Years Months Days If less than one day  
73 3 10 hrs. min.9. Birthplace Poland  
(Town, county, and state)10. Usual occupation Retired

11. Industry or business

FATHER 12. Name Unknown13. Birthplace PolandMOTHER 14. Maiden name Unknown15. Birthplace Poland16. Informant Mrs. Elizabeth YostAddress 521 46th Street17. Burial Date thereof July 1, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. StanislausLocation Mt. Carmel Road18. Funeral director M. F. Sadowski & SonsAddress 1808 Eastern Avenue19. June 30, 1948 a. w. Hefsch  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 4:50 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 48 to June 27, 1948and that I last saw him alive on June 27, 1948Immediate cause of death Cardiac failureDue to Chronic Passive CongestionDue to arterio-sclerotic Cardio-vascular disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: if death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Joseph G. Givoli M.D. M. D. or otherAddress 422 Eastern Ave Date signed 6/28/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

5883

## 1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

Street No. ....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business

MOTHER FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17.

(Burial, cremation, or removal, Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19.

(Date rec'd by registrar)

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## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

19..

at

6 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., 10....., 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically:

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, ~~suicide~~, or homicide.....

Where did injury occur?.....

Injured at home, farm, industry, public place (where?).....

Means of injury.....

23. SIGNATURE.....

Address.....

Date.....



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5884

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Belts. Co. Md.City or town Dundalk 22  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Nannie Rose Coleman

## 3. (b) Social Security Number

4. Sex Female 5. Color or race col. 6. (a) Single, married, widowed, or divorced Widow

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.) July 2, 1894

6. (c) If alive, give age ..... years

8. AGE:

Years 53

Months

Days

If less than one day

..... hrs. .... min.

9. Birthplace

Dale, Va.

(Town, county, and state)

10. Usual occupation

House work

11. Industry or business

FATHER  
MOTHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty Belts 22 mdCity or town Turner Station

(If outside city or town limits, write RURAL and give nearest town)

Street No. 109 Barbervy court

(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 18,1948 at 1:35 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16,1948 to June 18,1948and that I last saw him alive on June 18,1948

Immediate cause of death

Bronchial Pneumonia

DURATION

2 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William G. Wade, M.D.

M. D. or other

Address

140 Oak AveDate signed 6-19-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5885

Reg. Dist. No. 41

### 1. PLACE OF DEATH:

County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
117 Dundalk Avenue  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Baltimore  
City or town Dundalk  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 117 Dundalk Ave.  
(If rural, give LOCATION)  
2. (a) If veteran, name war.

### 3. (a) FULL NAME

Ida Eugenia Collins

### 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6. (a) Single, married, widowed, or divorced M  
6. (b) Name of husband or wife Asa S. Collins  
6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) December 22, 1869  
8. AGE: Years 78 Months 5 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
(Town, county, and state)  
10. Usual occupation Housewife

### 11. Industry or business

12. Name Wm. Constantine  
13. Birthplace Md.  
14. Maiden name Sarah Wheat  
15. Birthplace Md.

16. Informant Ethel A. Oberle  
Address 34 Partnership Road  
17. Burial Date thereof June 5, 1948  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore  
Location East North Ave. Baltor, Md.  
18. Funeral director Roland C. Fisher  
Address 2112 Dundalk Ave.

19. June 3 19 48 William M. Keely Jr.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 1 June 48 at 8:50 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 46 to 1 June 48  
and that I last saw him alive on 31 May 48

Immediate cause of death Congestive heart failure DURATION 1 month

Due to Coronary thrombosis 2 years

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Bernard W. Doreed M. D. or other  
Address 8 Liberty Parkway Date signed 1 June 1948

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 7 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

### 1. PLACE OF DEATH:

County Baltimore  
City or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 0 yrs., 0 mos., 4 days  
Hospital, institution, or street address where death occurred: Mt. Wilson Branch, Md. T. B. Sanatorium  
How long in hospital or institution? 0 yrs., 0 mos., 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Anne Arundel  
City or town R. F. D. Bay Ridge, Annapolis  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (a) FULL NAME

Mrs. Hilda Covington

3. (b) Social Security Number  
# Unknown

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Melvin Covington

6. (c) If alive, give age 23 years

7. Birth date of deceased (mo., day, yr.) September 11, 1916

8. AGE: Years 31 Months 8 Days 26 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Annapolis, Maryland  
(Town, county, and State)

10. Usual occupation Housewife

11. Industry or business \_\_\_\_\_

12. Name Charles C. Taylor

13. Birthplace Annapolis, Maryland

14. Maiden name Augusta Crandell

15. Birthplace Galesville, Maryland

16. Informant Mrs. Hilda Covington

Address R. F. D. Bay Ridge, Annapolis, Md.

17. Burial Date thereof June 9, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cedar Bluff Cemetery

Location Annapolis, Maryland

18. Funeral director John Taylor

Address Annapolis, Maryland

19. June 6, 1948 Helen R. Mayer  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 6, 1948 at 12:18 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 2, 1948 to June 6, 1948 and that I last saw her alive on June 6, 1948

Immediate cause of death Pulmonary Tuberculosis DURATION 15 mos.

Due to Tubercle Bacilli

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stewart S. Shaffer M.D.

Address Mt. Wilson, Md. Date signed 6/6/48

Dr. E. E. Nichols - 6-8-48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

CERTIFICATE OF DEATH

STATE OF NEW YORK

County of ...

City of ...

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RECEIVED  
JUN 9 1948  
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore

City or town Delta, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Delta  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hollow Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Jannie Catherine Cross

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Osborn M. Cross

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) April 17, 1888.

8. AGE: Years 60 Months 1 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Winfield Carroll Co. Md.  
(Town, county, and state)

10. Usual occupation Housewife

### 11. Industry or business

12. Name Calvin Eyer

13. Birthplace Maryland

14. Maiden name Mary A. Ditzler

15. Birthplace Baltimore, Maryland

16. Informant Mrs. Helen Daniels

Address Delta, Maryland

17. Burial Date thereof June 7, 1948.  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. John's Cemetery

Location Ellicott City, Maryland

18. Funeral director Easton Sons

Address Ellicott City, Maryland

19. 6-7 19 48 W.E. Harris  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 4, 19 48 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1948 to June 4, 1948 and that I last saw him alive on June 4, 1948

Immediate cause of death

Carcinoma of uterus with generalized metastases

DURATION

17 yrs

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

W.E. Harris  
Ellicott City, Md.

M. D. or other

Address \_\_\_\_\_ Date signed 6/5/48

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 8 1948

BUREAU V. S.

Reg. Diat. No. ....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

<b>1. PLACE OF DEATH:</b> County <u>Baltimore</u> City or town <u>Catonsville</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>10 days</u> Hospital, institution, or street address where death occurred: <u>17 Tuxbury Ave House in River</u> How long in hospital or institution? _____		<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>MD</u> County _____ City or town <u>Baltimore City</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>4812 Independence Ave</u> (If rural, give LOCATION) 2(a) If veteran, name war _____	
<b>3. (a) FULL NAME</b> <u>Edward J. Cullen</u>		<b>3. (b) Social Security Number</b> _____	
<b>4. Sex</b> <u>M.</u>	<b>5. Color or race</b> <u>W.</u>	<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>	
<b>6. (b) Name of husband or wife</b> <u>Catherine McConnell</u>		<b>6. (c) If alive, give age</b> _____ years	
<b>7. Birth date of deceased (mo., day, year)</b> <u>Nov 1873 or 1872</u>		<b>8. AGE:</b> Years _____ Months _____ Days _____ If less than one day _____ hrs. _____ min.	
<b>9. Birthplace</b> <u>Ireland</u> (Town, county, and state)		<b>10. Usual occupation</b> <u>Retired</u>	
<b>11. Industry or business</b> <u>John J. Cullen</u>		<b>12. Name</b> <u>Mary Clark</u>	
<b>13. Birthplace</b> <u>Ireland</u>		<b>14. Maiden name</b> <u>Ireland</u>	
<b>15. Birthplace</b> <u>Ireland</u>		<b>16. Informant</b> <u>Miss Marie Mc Namara</u> Address <u>1812 Independence Ave</u> <u>Baltimore</u> Date thereof <u>6/1/48</u> (Burial, cremation, or removal. Which?) _____ (month) (day) (year)	
<b>17. Cemetery or crematory</b> <u>Catholic</u> <u>St. Ignace R.C.</u>		<b>18. Funeral director</b> <u>J. J. Lohr &amp; Sons</u> Address <u>613 40 A.W. Hedrick</u> <u>MD</u> Registrar	
<b>19. (Date rec'd by registrar)</b> <u>6/3/48</u>		<b>20. DATE OF DEATH</b> <u>6/2/48</u> 19 <u>48</u> , at <u>8:15 PM</u>	
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>3/2/48</u> 19 <u>48</u> to <u>6/1/48</u> 19 <u>48</u> and that I last saw him alive on <u>5/30/48</u> 19 <u>48</u>		<b>22. MEDICAL CERTIFICATION</b> Immediate cause of death <u>Congestive heart failure</u> Due to <u>Arterio sclerosis</u> Due to <u>Coronary atherosclerosis</u> Other conditions <u>none</u> (Include pregnancy within 3 months of death) Major findings of operations <u>none</u> Date of op. _____ Autopsy results <u>none</u> PHYSICIAN: Please underline the cause to which death should be charged statistically. <u>Arterio sclerosis</u> <u>Coronary atherosclerosis</u> <u>Congestive heart failure</u>	
<b>23. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of Injury _____ Injured at work? _____ Signature <u>Chas. L. Norton Jr</u> M. D. or other _____ Address <u>1433 W. Belts St</u> Date signed <u>6/2/48</u>			

1948  
75  

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1873

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Life correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5889

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months, 11 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 3 months, 11 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Baltimore  
 City or town Relay  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Viaduct Ave. - 5163  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war -

## 3. (a) FULL NAME

Annie Daugerty

## 3. (b) Social Security Number

-

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife ALEXANDER Daugherty

7. Birth date of deceased (mo., day, yr.) November 30, 1874 6. (c) If alive, give age - years

8. AGE: Years 78 Months 6 Days 14 If less than one day - hrs. - min.

9. Birthplace Maryland, BALTO.  
 (Town, county, and state)

10. Usual occupation housewife

11. Industry or business home

FATHER 12. Name Conrad STUMP

13. Birthplace Germany

MOTHER 14. Maiden name Martha ?

15. Birthplace Germany

16. Informant Hospital Records MRS. IRENE FERGAN

Address Catonsville 28, Md. ST. DENIS - 27

17. BURIAL Date thereof 6/17/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory London PK

Location BALTO. MD.

18. Funeral director Wm T. T. K. WERTS

Address BALTO. MD.

19. 6/16 19 48 AW Hedgill  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 48 at 2:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 3 19 48 to June 14 19 48

and that I last saw her alive on June 14 19 48

Immediate cause of death Pneumonia DURATION 45 hrs

rx low lobe 72"

Subarachnoid & cerebral hemorrhage Stroke

Due to Q. M. Arteriosclerosis "

Art scler. heart disease "

Due to Myocard. infarct (old) "

Hypert. C.V. disease "

Other conditions Chronic nephritis "

Diabetes Mellitus "

(Include pregnancy within 3 months of death)

Major findings of operations - Date of op. -

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) - (County) - (State)

Injured at home, farm, industry, pub'c place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Isadore Tuerk, M.D. Spring Grove St. Hosp. M. D. or other -

Address Catonsville, Md. Date signed 6/14/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

5890

93d

## 1. PLACE OF DEATH:

County Balto.City or town Overlea  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

5903 Kenwood Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Overlea  
(If outside city or town limits, write RURAL and give nearest town)Street No. 5903 Kenwood Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Margaret Margit Delbo

## 3. (b) Social Security Number

4. Sex

F.

5. Color or race

W.

6. (a) Single, married, widowed, or divorced

W. downd

6. (b) Name of husband or wife

John

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

June 19 1856

8. AGE:

Years

Months

Days

If less than one day

911123

hrs.

min.

9. Birthplace

Hungary  
(Town, county, state)

10. Usual occupation

11. Industry or business

At Home

12. Name

Andrew Bonchue

13. Birthplace

Hungary

14. Maiden name

15. Birthplace

Hungary

16. Informant

John Delbo

Address

5903 Kenwood Ave

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Holy Redeeman

Location

4300 Belair Rd.

18. Funeral director

Dippel Bros

Address

7110 Belair Rd.

19.

(Date rec'd by registrar)

6/14 48 ASD Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 1948 at 2 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 10 1948 to June 12 1948and that I last saw him alive on June 8 1948

Immediate cause of death

Arterio-Sclerosis

Due to

myocardial

Due to

thrombocytosis

Other conditions

(Include pregnancy within 3 months of death)

DURATION

10 yrs3 mos

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

St. Vincent's

M. D. or other

Address 1111 Overlea Date signed 6/14/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

5891

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 36 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 36 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 920 Greenmount Ave.  
(If rural, give LOCATION)2.(a) If veteran, name war VW ✓

## 3. (a) FULL NAME

HERMAN DORSEY

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Elizabeth Dorsey7. Birth date of deceased (mo., day, yr.) June 1, 1892  
6. (c) If alive, give age 38 years8. AGE: Years 56 Months 0 Days 0 It less than one day  
..... hrs. .... min.9. Birthplace St. Mary's County, Md.  
(Town, county, and state)10. Usual occupation Chauffeur

## 11. Industry or business

12. Name August Dorsey13. Birthplace Maryland14. Maiden name Theresa (Unknown)15. Birthplace Maryland16. Informant Veterans Administration Clin. RecordsAddress Fort Howard, Md.17. Burial Date thereof June 5, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Charles R. LawAddress 802 Madison Ave., Baltimore, Md.19. 6/2 19 45 H. W. Reduek  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 1 19 48 at 6:55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 26 19 48 to June 1 19 48  
and that I last saw him alive on June 1 19 48Immediate cause of death Chr. Nephritis and hypertension  
DURATION Unknown

Due to

Due to

Other conditions none

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Paul O. Anderson  
P. O. ANDERSON, M. D. M. D. or otherAddress V. A. H. FORT HOWARD, MD. Date signed 6-1-48



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County..... **BALTIMORE**City or town..... **TOWSON**  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?..... **Since July 18, 1939**

Hospital, institution, or street address where death occurred:

**SHEPPARD AND ENOCH PRATT HOSPITAL**How long in hospital or institution?..... **Since July 18, 1939**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... **Maryland** County..... **Balto.**City or town..... **Baltimore**  
(If outside city or town limits, write RURAL and give nearest town)Street No..... **2911 Roslyn Avenue**  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

**DUCK, Mrs. Susan Sheppard**

## 3. (b) Social Security Number

**None**

4. Sex

**Female**

5. Color or race

**White**

6. (a) Single, married, widowed, or divorced

**Widow**6. (b) Name of husband or wife..... **Dr. Charles E. Duck**

8. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

**January 1, 1848**

8. AGE:

Years

Months

Days

If less than one day

**100****5****9**

hrs.

min.

9. Birthplace..... **Baltimore City**

(Town, county, and state)

10. Usual occupation..... **None**

11. Industry or business

FATHER

12. Name..... **Thomas Sheppard**13. Birthplace..... **Maryland**

MOTHER

14. Maiden name..... **Barbara Deems**15. Birthplace..... **Maryland**16. Informant..... **HOSPITAL RECORDS**Address..... **Sheppard-Rate Hospital, Towson 4, Md.**17. **Burial** Date thereof..... **8/11/48**  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... **Green Mount**Location..... **Baltimore**18. Funeral director..... **William J. ...**Address..... **1217 ...**19. **June 11, 1948** **R. W. Hedrick**  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... **June 10, 1948** at **1:25 P.M.**21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
**July 18, 1939** to **June 10, 1948**and that I last saw him **alive** on **June 10, 1948**Immediate cause of death..... **Chronic organizing****bronchopneumonia**

DURATION

**1 week**Due to..... **Chronic myocardial****degeneration**

Due to.....

Other conditions..... **Severe psychosis**

(Include pregnancy within 3 months of death)

Major findings of operations.....

Autopsy results..... **Confirms above.**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... **W. W. Elgin, M.D.** M. D. or otherAddress..... **Towson, Md.** Date signed..... **June 10, 1948**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

5893

## 1. PLACE OF DEATH:

County.....Baltimore  
 City or town.....Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 2 yrs., 0 mos., 16 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. T.B. Sanatorium  
 How long in hospital or institution? 2 yrs., 0 mos., 16 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland County.....Mont. Co., Md.  
 City or town.....Bethesda  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 4710 Edgemore Lane  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....✓

## 3. (a) FULL NAME

Thomas Leslie Easterling

## 3. (b) Social Security Number

None

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife.....Edith S. Moore Easterling

## 7. Birth date of

deceased (mo., day, yr.)

February 16, 1884

## 8. AGE:

Years

64

Months

4

Days

0

If less than one day

hrs.

min.

8. Birthplace.....Cokomo, Indiana

(Town, county, and state)

10. Usual occupation.....Economist

## 11. Industry or business

FATHER

12. Name.....Alvin B. Easterling13. Birthplace.....Indiana

MOTHER

14. Maiden name.....Minnie Cosand15. Birthplace.....Indiana16. Informant.....Thomas L. EasterlingAddress.....4710 Edgemore Lane, Bethesda, Md.

## 17.

Cremation

Date thereof.....

June 19, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory.....

Cedar Hill Crematorium

Location.....

Suitland, Maryland18. Funeral director.....William E. PumphreyAddress.....7557 Wisconsin Ave., Bethesda

## 19.

6/16/19. 48Helen R. Meyer

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....June 16, 1948 10:30 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 31, 1946 to June 16, 1948and that I last saw him alive on June 16, 1948

Immediate cause of death.....

Pulmonary Tuberculosis

DURATION

11 yrs.Due to.....Tubercle Bacilli

Due to.....

Other conditions.....MyocarditisUnknown

(Include pregnancy within 3 months of death)

Major findings of operations.....

No operation

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause in which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work? .....

23. SIGNATURE.....Stewart S. Shaffer m.d.

M.D. or other

Address.....Mt. Wilson, Md. Date signed.....6/16/48Dr. E. E. Nichols - Physician 6-19-48

RECEIVED

JUN 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

5894

## 1. PLACE OF DEATH:

County BaltimoreCity or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yrs

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Baltimore Md  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2905 Walbrook Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles Thomas Eberhart

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widower

## 6. (b) Name of husband or wife

Lula L. Eysinger

6. (c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

June 28 - 1862

## 8. AGE:

Years

Months

Days

If less than one day

851112

hrs.

min.

## 9. Birthplace

Baltimore Md  
(Town, county, and state)

## 10. Usual occupation

Clerical Work

## 11. Industry or business

Geo. W. Eberhart

## 12. Name

Baltimore Md

## 13. Birthplace

Mary W. Jones

## 14. Maiden name

Baltimore Md

## 15. Birthplace

Laura M. Schroeder

## 16. Informant

Cockeysville Md

## 17. Burial

Funeral

## 18. Cemetery or crematory

London Park

## 19. Location

Balto. Md

## 20. Funeral director

Wm. Cook

## 21. Address

St. Paul & Paxton St.

## 22. Date rec'd by registrar

June 10 19 48

## 23. Registrar

L. M. Schroeder

## MEDICAL CERTIFICATION

## 2D. DATE OF DEATH

June 9 19 48 at 3:30 A.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 7 19 48 to June 9 19 48and that I last saw him alive on June 8 19 48

## Immediate cause of death

Cerebral Accident

## DURATION

3 days

## Due to

Arterial Sclerosis4 yrs

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Walter T. Kees M.D.Address Cockeysville Md Date signed 6/9/48

**RECEIVED**

JUN 11 1948

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Balts  
City or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution or street address where death occurred:

Martin Aero Plant.  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balts.  
City or town Middle River  
(If outside city or town limits, write RURAL and give nearest town)  
Street 1311 3rd. Road (Stanbury Hwy)  
(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Edward C. Eden.

## 3. (b) Social Security Number

189-09-6616

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Kathryn Eden nee

7. Birth date of deceased (mo., day, yr.)

May 12 - 1908  
8. AGE: Years 40 Months 1 Days 18 If less than one day  
.....hrs. ....min.

9. Birthplace Bysonia, Penna.  
(Town, county, and state)10. Usual occupation Mechanic11. Industry or business Glenn L. Martin Co.12. Name William Eden13. Birthplace Pitts., Pa.14. Maiden name Edna Williams15. Birthplace Gettysburg, Pa.16. Informant Glenn L. Martin RecordAddress Middle River, Md.17. Removal Date thereof July 1st 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....

Location Haystack, Pa.18. Funeral director John G. ConnellyAddress 418 Eastern Ave. Essex19. July 1st 1948 John G. Connelly  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 30 1948 at 11:07 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19..... to .....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death.....

Coronary Occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE William M. D.Address Baltimore, Md. Date signed 10/30/48



**RECEIVED**

AUG 5 1948

**BUREAU V. S.**

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5896

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 24 years, 5 months, 5 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 24 years, 5 months, 5 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County   
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 605 South Bond Street  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Lee Elsasser

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 1907? 6.(c) If alive, give age  years

8. AGE: Years 41 Months ? Days ? If less than one day  hrs.  min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Unknown

11. Industry or business ?

FATHER 12. Name Isaac Elsasser

13. Birthplace Germany

MOTHER 14. Maiden name Johanna ?

15. Birthplace Germany

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof 6-17-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematorium Hebrew Friendship Cem

Location Jack Lewis, Inc

18. Funeral director 2100 Eutaw Place

Address 6-16

19. 19 48 V.E. Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 48 at 10:55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 9 19 24 to June 14 19 48

and that I last saw him alive on June 14 19 48

Immediate cause of death Acute pulmonary oedema

Acute cardiac failure

Due to Myxoedema

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of

Where did injury occur?  (City or town)  (County)  (State)

Injured at home, farm, industry, public place (where?)

Means of injury  Injured at work?

Signature Isadore Tuerk, M.D.

Address Catonsville-28, Maryland Date signed 6-15-48

23. SIGNATURE Isadore Tuerk

M. D. or other

Address Catonsville-28, Maryland Date signed 6-15-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5897

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Cockeysville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Lifetime  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Cockeysville (Rural)  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Forest Rd. on Fallb. Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war No

## 3. (a) FULL NAME

Albert M. Ensor

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Matilda (nee Ensor)

## 7. Birth date of

deceased (mo., day, yr.)

Apr. 13, 1874

## 6. (c) If alive, give age

## 8. AGE:

Years

Months

Days

If less than one day

74120

hrs.

min.

## 9. Birthplace

Balto. Co. Md.

(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## MOTHER

## FATHER

## 12. Name

Orville Ensor

## 13. Birthplace

Balto. Co. Md.

## 14. Maiden name

Siggie D. F. Ensor

## 15. Birthplace

Balto. Co. Md.

## 16. Informant

Gerald M. Ensor

## Address

Cockeysville, Md.17. Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

June 6, 1948

## Cemetery or crematory

Bosleys

## Location

Sparks, Md.

## 18. Funeral director

Sandon M. Brooks

## Address

Sparks, Md.

## 19.

6-3-19 48Wilmer C. Ensor

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 319 48

at

7 A. M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-1-1948to June 319 48

## and that I last saw him alive on

June 219 48

## Immediate cause of death

Angina Pectoris

## DURATION

1 yr.

## Due to

Atherosclerosis

## Due to

Hypertension

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. ✓

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓Date of ✓

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of Injury

Injured at work? ✓

## 23. SIGNATURE

James G. Saffell

M. D. or other

## Address

Baltimore, Md.Date signed 6-3-48

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JUN 8 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore

City or town Cockeysville Md.  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? born there

Hospital, institution, or street address where death occurred:

Masonic Home, Cockeysville Md

How long in hospital or institution? born there

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Tallot

City or town Easton Md  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 S. Washington St

(If rural, give LOCATION)

2.(a) If veteran, name war. ✓

### 3. (a) FULL NAME

Bayne Fields

### 3. (b) Social Security Number

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Cinda R. Fields

7. Birth date of deceased (mo., day, yr.) July 8th 1860

6.(c) If alive, give age 83 years

8. AGE: Years 83 Months 11 Days 13 It less than one day

hrs. min.

9. Birthplace Seaford Delaware  
(Town, county, and state)

10. Usual occupation Barber

11. Industry or business

12. Name Stephen B. Fields

13. Birthplace Wacomico Md

14. Maiden name Clara Corington

15. Birthplace Seaford Del.

16. Informant Paul M. Schroeder

Address Masonic Home, Cockeysville

17. Burial Date thereof 6-23-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Spring Hill Cemetery

Location Easton Md

18. Funeral director Wm. Cook

Address St. Paul & Preston St

19. 6-22-1948 F.M. Schroeder  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 21 1948 at 10:15 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1948 to June 21 1948

and that I last saw him alive on June 21 1948

Immediate cause of death Cerebral Vascular Accident DURATION 1 day

Due to Hypertension 15 yrs

Due to Arterio sclerosis

Other conditions Cardiac Decompensation  
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter T. Keo M.D. M. D. or other

Address Cockeysville Md Date signed 6/21/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **30**

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Opitz Home Edmondson Ave

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County —

City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1207 Battery Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name War ☒

## 3. (a) FULL NAME

Elizabeth M. Finnerty

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

B.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Aug. 10 - 1880

8. AGE: Years Months Days If less than one day

67 - - — hrs. — min.

9. Birthplace

Baltimore Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business Emmerson Drug Co.12. Name Michael Finnerty13. Birthplace Ireland14. Maiden name Ellen Mahoney15. Birthplace Ireland16. Informant Miss Nellie J. MitchellAddress 3002 Presbury St.17. Burial Date thereof 6-16-1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory CathedralLocation Baltimore Md.18. Funeral director Flynn - FlemingAddress 1426 Light St.19. 4-15-48 Overland  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/14/48 19 48, at \_\_\_\_\_ M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1948 to June 14, 1948and that I last saw her alive on June 13, 1948Immediate cause of death Cerebralhemorrhage

## DURATION

Due to General & Cerebralarterio sclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Harry Keene M. D. or otherAddress 1226 Hanover St Date signed 6/14/48



RECEIVED

JUN 9 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. \_\_\_\_\_

5901

462

1. PLACE OF DEATH: Baltimore Co  
County Berkshire Md  
City or town (If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution: 7466 Berkshire Rd  
Slay in hospital or inst. (yrs., or mos., or days) \_\_\_\_\_  
Slay in this community (yrs., or mos., or days) 20 yrs

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State Md County Baltimore  
City or town Berkshire Md Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 7466 Berkshire Rd  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR 2nd World War

3. (a) FULL NAME Retired Captain John Fredericks (Fredorcho)  
3. (b) Social Security Number \_\_\_\_\_

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6 (b) Name of husband or wife Ruby E. Baker  
Fredericks 6 (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Nov. 13, 1905  
8. AGE: Years 42 yrs Months 6 Days 29 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Newark N.J.  
(Town, county, and state)  
10. Usual occupation Retired Captain in U.S.A.

11. Industry or business \_\_\_\_\_  
FATHER 12. Name Michael Fedorcho  
13. Birthplace Europe  
MOTHER 14. Maiden name Anna Farchak  
15. Birthplace Europe  
16. Informant Mrs Ruby E. Fredericks  
Address 7466 Berkshire Rd

17. Burial Date thereof June 15, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Baltimore Nat Cemetery  
Location 355 Frederick Ave  
18. Funeral director Elmer W. Conklin's Son  
Address 924 E. Eager St.  
19. 6/14 19 48 A.W. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 12 19 48, at 12 P.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 19 47, to June 12 19 48, and that I last saw him alive on 11 June 19 48.

Immediate cause of death Generalized Carcinomatosis DURATION 1 year  
Due to Carcinoma of Rectum 6 years  
Due to \_\_\_\_\_

Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings: \_\_\_\_\_  
Of operations \_\_\_\_\_  
Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE M. A. Jacobs MD M. D. or other \_\_\_\_\_  
Address 617 North Pt Rd Date signed 6/13/48

### PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Wm. Morris

617 Maple Point Rd.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

5902

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 yrs., 10 mos., 9 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson Br.  
Md. T.B. Sanatorium  
 How long in hospital or institution? 9 yrs., 10 mos., 9 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)  
 State Maryland County Baltimore  
 City or town Riderwood, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Roldrew Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Leonard E. Greaver

## 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife Florence M. Greaver

7. Birth date of deceased (mo., day, yr.) March 2, 1873 6.(c) If alive, give age ..... years

8. AGE: Years 75 Months 3 Days 8 It less than one day ..... hrs. .... min.

9. Birthplace Augusta Co., Va.  
 (Town, county, and state)

10. Usual occupation Laborer

11. Industry or business

12. Name Jacob Greaver13. Birthplace Augusta Co., Va.14. Maiden name Isabella Clements15. Birthplace Virginia16. Informant Leonard E. GreaverAddress Riderwood, Md.

17. Burial Date thereof June 14, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Thornrose CemeteryLocation Staunton, Va.18. Funeral director John Burns & SonsAddress Towson, Md.

19. June 10 19 48 Walter R. Meyer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10, 19 48, at 6:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 1, 19 38, to June 10 19 48  
 and that I last saw him alive on June 10 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION 10 yrs.

Due to Tubercle BacilliDue to Stomach Ulcer 10 yrs.

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE Stewart S. Shaffer M.D. M. D. or otherAddress Mount Wilson, Md. Date signed 6/10/48

Dr. E. E. Nichols - 6-14-48

RECEIVED

JUN 15 1948

BUREAU V. S.

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## STATE OF MARYLAND—CERTIFICATE OF DEATH

5903

## 1. PLACE OF DEATH

County

Baltimore

Village or City

Lutherville

Registration Dist. No.

38

No.

Seminary Avenue

St.

Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred

yrs.

mos.

ds.

How long in U. S. if of foreign birth?

yrs.

mos.

ds.

## 2. FULL NAME

Somerset Spencer Greenwell

(a) Residence: No.

Seminary Ave, Lutherville, Md.

Ward.

(Usual place of abode)

If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX

Male

4. COLOR OR RACE

White

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

Widowed

5e. If married, widowed, or divorced  
HUSBAND of  
(or) WIFE of

Bertha S. Greenwell

6. DATE OF BIRTH (month, day, and year)

Jan. 17, 1862

Approximately 1856

7. AGE

Years

Months

Days

If LESS than  
1 day, \_\_\_\_\_ hrs.  
or \_\_\_\_\_ min.

OCCUPATION

8. Trade, profession, or particular  
kind of work done, as SPINNER,  
SAWYER, BOOKKEEPER, etc.

Retired

9. Industry or business in which  
work was done, as SILK MILL,  
SAW MILL, BANK, etc.

Minister

10. Date deceased last worked at  
this occupation (month and  
year)

—

11. Total time (years)  
spent in this  
occupation12. BIRTHPLACE (city or town)  
(State or country)

St. Mary's Co., Md.

FATHER

13. NAME

Unknown

14. BIRTHPLACE (city or town)  
(State or country)

"

MOTHER

15. MAIDEN NAME

Unknown

16. BIRTHPLACE (city or town)  
(State or country)

"

17. INFORMANT

Charles H. McComas

(Address)

Bel Air, Maryland

18. BURIAL, CREMATION, OR REMOVAL

Gunpowder Church Cem.

Place

Cockeysville, Md.

Date

June 12, 1948

19. UNDERTAKER

(Address)

John Burns & Sons  
Towson, Md.

20. FILED

June 12, 1948

John Burns & Sons  
Towson, Md.

## MEDICAL CERTIFICATE OF DEATH

## 21. DATE OF DEATH

June

9

1948

(Month)

(Day)

(Year)

22. I HEREBY CERTIFY, That I attended deceased from  
such, 1948, to 9 June, 1948

I last saw him alive on

9 June

19

48; death is said

to have occurred on the date stated above, at 9:20 P. m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance  
were as follows:

Arterio-sclerotic

Cardio-vascular disease

Date of onset

March 1948

Other Contributory Causes of Importance:

Name of operation

None

Date of

What test confirmed diagnosis?

Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide?

Date of injury

19

Where did injury occur?

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify

(Signed)

Charles H. McComas

M. D.

(Address)

6701 York Rd Balt 12 Md

# UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>

Other contributory causes of importance:

<i>Gallstones</i>	<i>May 1, 1923</i>
-------------------	--------------------

Example II

The principal cause of death and related causes of importance were as follows:

	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>

Other contributory causes of importance:

<i>Gastroenteritis</i>	<i>1 year</i>
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ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5904

Reg. Dist. No. 171-31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Granite

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rail road on W. old Court Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty BaltimoreCity or town Granite

(If outside city or town limits, write RURAL and give nearest town)

Street No. Rail road on W. old Court Rd

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Charles A Hall

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

1883

8. AGE:

Years

Months

Days

If less than one day

65

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

None

11. Industry or business

12. Name

Charles Hall

13. Birthplace

Maryland

14. Maiden name

Louise Green

15. Birthplace

Virginia

16. Informant

Mary Grant

Address

GraniteMd

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6-7-48

(month) (day) (year)

Cemetery or crematory

Cherry Hill

Location

GraniteMd

18. Funeral director

F.C. Higinbotham

Address

Ellicott City, Md

19. June 7

(Date rec'd by registrar)

19 48John B. Loughman  
Reg. B. E. R. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 4 48 3-30p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19

and that I last saw him alive on 19

Immediate cause of death

DURATION

Acute Coridial failure

Due to

Cardiovascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. W. H. Hoffer  
Ed. H. Hoffer

M. D. or other

Address

1010 Leeds onDate signed June 48

RECEIVED

AUG 7 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5905

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County BaltimoreCity or town Texas  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 yrs. 16 da. 16 da

Hospital, institution, or street address where death occurred:

Baltimore County HomeHow long in hospital or institution? 18 yrs. 16 da. 16 da

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Texas  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Jerry Hall

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

col

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife Mrs Catherine Brown Hall

6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Dec. 26, 18838. AGE: Year Months Days If less than one day  
64 5 14 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace North Carolina  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name Thomas Hall13. Birthplace N. Carolina14. Maiden name Leona Hares15. Birthplace N. Carolina16. Informant Baltimore County Home RegisterAddress Texas Md.17. Buried Date thereof June 12 - 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore County Home Cem.Location Texas Md.18. Funeral director Leona M. BrooksAddress Sparks Md.19. 6/10 19 48 W. J. Whitworth  
(Date reg'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/10 19 48 at 1 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 29 19 39, to 6/10 19 48and that I last saw him alive on 6/8 19 48Immediate cause of death Carcinoma - Lungs DURATION 1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other condition \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Major findings of operations \_\_\_\_\_

\_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

\_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

\_\_\_\_\_

23. SIGNATURE William C. Furrow DAddress Cockeysville Md Date signed 6/10/48

RECEIVED

JUN 18 1948

BUREAU V. S.

ITEMS 6a and 6b changed by evidence

shown on ::::

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. G 116 JUN 10 1948

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH

County Balto.City or town Back River  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

North East Creek

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)Street No. 220 Poplar Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

William Garfield Hancock.

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife Amelia B. Heffner

## 7. Birth date of

deceased (mo., day, yr.)

Dec 12 / 1881.6. (c) If alive, give age 30 years

## 8. AGE:

Years

Months

Days

If less than one day

66523hrs.min.

## 9. Birthplace

Balto Md.  
(Town, county, and state)

## 10. Usual occupation

Lab.

## 11. Industry or business

Am. Can.

## MOTHER

## FATHER

## 12. Name

Garrett W. Hancock

## 13. Birthplace

Md.

## 14. Maiden name

Hannah C. Burlingame

## 15. Birthplace

Md.

## 16. Informant

Mrs. E. F. Heffner

## Address

167 Riverside Rd. Daughter

## 17. (Burial, cremation, or removal, Which?)

Burial

## Date thereof

6/17/48  
(month) (day) (year)

## Cemetery or crematory

Moreland Memorial

## Location

Taylor Ave.

## 18. Funeral director

John D. Connelly

## Address

418 Eastern Ave. Essex

## 19.

6/14/48

## 19.

John D. Connelly

(Date read by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 14 19 48 at 6:00 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48, to 19 48and that I last saw him alive on 19 48

Immediate cause of death

DURATION

Drowning

Due to

(Suicide)

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Suicide Date of 6/14/48Where did injury occur? Essex Balto Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Public PlaceMeans of injury Drowning Injured at work? no

## 23. SIGNATURE

McBarnum M.D.Address Balto Co. Dundalk Date signed 6/14/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

163M

5907

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

## 1. PLACE OF DEATH:

County BaltimoreCity or town Dundalk - m  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto.City or town 50 S. Dundalk Ave  
(If outside city or town limits, write RURAL and give nearest town)Street No. Tom Dundalk - m

(If rural, give LOCATION)

2. (a) If veteran, name war W. W. 1

## 3. (a) FULL NAME

William Sidney Harrington

## 3. (b) Social Security Number

213-07-0168

## 4. Sex

m

## 5. Color or race

w

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Flora T. Harrington

## 7. Birth date of deceased (mo., day, yr.)

April 10<sup>th</sup> 1898

## 6. (c) If alive, give age years

## 8. AGE:

50

Years

Months

1

Days

28

If less than one day

hrs.

min.

## 9. Birthplace

Saultville Va

(Town, county, and state)

## 10. Usual occupation

Fireman - Mechanical Dept.

## 11. Industry or business

Bethlehem Steel

FATHER

## 12. Name

Edward Harrington

## 13. Birthplace

England

MOTHER

## 14. Maiden name

Edith Thomas

## 15. Birthplace

Wales

## 18. Informant

Flora T. Harrington

## Address

50 S. Dundalk Ave

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

6/11/48  
(month) (day) (year)

## Cemetery or crematory

Harrisburg

## Location

" Pa.

## 18. Funeral director

William Cook Inc

## Address

1217 St. Paul St

## 19.

June 10 19 48  
(Date rec'd by registrar)A. W. Hedrick  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8<sup>th</sup> 19 48 at 10<sup>20</sup> M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

## Immediate cause of death

Carbon monoxide Poison

## DURATION

3 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 6/8/48Accident, suicide, or homicide suicide Date of 6/8/48Where did injury occur? Dundalk - m (Baltimore)  
(City or town) (State)Injured at home, farm, industry, public place (where?) garageMeans of injury overdose with car running Injured at work? no

23. SIGNATURE.....

M. B. Davis M.D.  
Address Dundalk - m Date signed 6/8/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH

County BaltoCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

"House in Pines" Nursing HomeHow long in hospital or institution? 16 Pasting Ave

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md CountyCity or town Balto  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1533 Acornth st  
(If rural, give LOCATION)2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Owen Henry Harrison

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Ellen M. Harrison

7. Birth date of deceased (mo., day, yr.)

June 25<sup>th</sup> 1865

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

821115

hrs.

min.

9. Birthplace

Md.  
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

Engineer

FATHER

12. Name

Owen H. Harrison

13. Birthplace

Md.

14. Maiden name

Charlotte Davis

15. Birthplace

Md.

16. Informant

Roman J. Steiner

Address

618 Murdock Rd

17.

(Burial, cremation, or removal, which?)

Date thereof

6/14/48

(month) (day) (year)

Cemetery or crematory

London Park

Location

Balto. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St.

19.

(Date rec'd by registrar)

6-12-48AM Newman

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 10<sup>th</sup> 1948 at 5 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 4 1948 to June 10 1948and that I last saw him alive on June 18 1948

Immediate cause of death

Acute Myocardial Decomposition

DURATION

1 day

Due to

Chronic Cardio-renal-vascular disease10 yrs (?)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

William K. Gallager M.D.

M. D. or other

Address Catonville 28, Md Date signed 6-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

1. PLACE OF DEATH: *Baltimore*  
 County.....  
 City or town..... *Rural - Sparks*  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? *2 years*  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... *Maryland* County..... *Baltimore*  
 City or town..... *Rural - Sparks*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. .... *York Road*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3. (a) FULL NAME

*Julia Nolen Hay*

## 3. (b) Social Security Number

4. Sex..... *Female* 5. Color or race..... *White* 6. (a) Single, married, widowed, or divorced..... *Widow*  
 6. (b) Name of husband or wife..... *Guillaume B. Hay*  
 6. (c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... *January 28, 1872*  
 8. AGE: Years..... *76* Months..... *4* Days..... *12* If less than one day..... hrs. .... min.

9. Birthplace..... *Tishomingo Co., Miss.*  
 (Town, county, and state)  
 10. Usual occupation..... *House wife*

11. Industry or business.....  
 12. Name..... *William P. Nolen*  
 13. Birthplace..... *Paducah, Kentucky*  
 14. Maiden name..... *Julia S. Cook*  
 15. Birthplace..... *Memphis, Tenn.*  
 16. Informant..... *Lillian Hay Regnley*  
 Address..... *Sparks, Md.*

17. *Removal* (Burial, cremation, or removal. Which?) Date thereof..... *June 17, 1948*  
 (month) (day) (year)  
 Cemetery or crematory..... *Fulton*  
 Location..... *Fulton, Kentucky*  
 18. Funeral director..... *Landrum M. Brooks*  
 Address..... *Sparks, Md.*  
 19. *6-20-48* Wilmer C. Ensor  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... *8 June 1948* at..... *6:15 P* M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... *June 1948* to..... *8 June 1948*  
 and that I last saw him/her alive on..... *8 June 1948*  
 Immediate cause of death..... *Heart failure* DURATION..... *1 1/2 yrs.*  
 Due to..... *Ar-terio sclerosis* 2 yrs.?  
 Due to.....  
 Other conditions..... *Par-kinson's Disease* 3 1/2 yrs.  
 (Include pregnancy within 3 months of death)

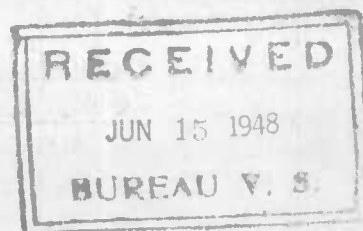
Major findings of operations..... Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town)..... (County)..... (State).....  
 Injured at home, farm, industry, public place (where?).....  
 Means of injury..... Injured at work?

23. SIGNATURE..... *Walter T. Kees M.D.*  
 Address..... *Cockeysville, Md.* M. D. or other.....  
 Date signed..... *8 June 1948*





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 months 27 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 3 months, 17 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Harford  
 City or town Whiteford  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Callie Knight Heaps

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 B. (b) Name of husband or wife Ira Heaps  
 6. (c) If alive, give age Unknown years  
 7. Birth date of deceased (mo., day, yr.) April 4, 1872  
 8. AGE: Years 76 Months 2 Days 23 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.  
 9. Birthplace Maryland  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name William Knight  
 13. Birthplace Maryland  
 14. Maiden name Lizzie Tyson  
 15. Birthplace Maryland

16. Informant Hospital Records  
 Address Catonsville, 28, Maryland  
 17. Burial Date thereof July 2, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Emory  
 Location Whiteford Rd  
 18. Funeral director Robert P. Perkins  
 Address Delta Pa.  
 19. 6-29 19 48 V.E. Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 19\_\_\_\_ at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

\_\_\_\_\_ 19\_\_\_\_ to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death

DURATION

Lobar Pneumonia  
Cardiovascular disease  
fracture of left femur  
 Other conditions \_\_\_\_\_  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide accident Date of 6-5-48  
 Where did injury occur? Catonsville Baltimore  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) hospital  
 Means of injury fall on floor Injured at work no  
 Signature Dr. W. Kieffer Edmund Bell  
 M. D. or other \_\_\_\_\_  
 Address 1010 Leckon Date signed 6-27-48

RECEIVED

JUL 2 1948

BUREAU V. S.

Evidence for change of  
age shown on:

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

462

5911

FILM No. G 116 JUL 2 1948

CERTIFICATE OF DEATH

Reg. Dist. No. ....

1. PLACE OF DEATH:

County Balto  
City or town Possibile md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md. County Balto  
City or town Possibile - md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3 E. Lenning Lane  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME

Mary Anna Hofmeister

3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed  
6.(b) Name of husband or wife Wolfgang  
6.(c) If alive, give age years  
7. Birth date of deceased (mo., day, yr.) 8/8/92  
8. AGE: Years 55 Months 56 Days  It less than one day  
hrs. min.

9. Birthplace Germany  
(Town, county, and state)  
10. Usual occupation Housewife  
11. Industry or business at home  
12. Name Joseph - father  
13. Birthplace Germany  
14. Maiden name ?  
15. Birthplace Germany

16. Informant Joseph Hofmeister (son)  
Address 3 E. Lenning Lane  
17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 6/8/48  
(month) (day) (year)  
Cemetery or crematory Holy Redeemer  
Location Bethesda Md.  
18. Funeral director Lilly & Zeile ch  
Address 403 1st Street St.  
19. 6/18 19 48 Dr. Medical  
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 19 48 at 8:10 P. M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 48 to June 25 19 48  
and that I last saw her alive on June 25 19 48  
Immediate cause of death Toxemia  
Due to Carcinoma of Rectum  
Due to  
Other conditions  
(Include pregnancy within 3 months of death)

DURATION

1 yr.

3 yrs.

Major findings of operations  
Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

3. SIGNATURE M Baumgardner M. D. or other  
Address Balto 6 md Date signed 6-25-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5912

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Mount Wilson  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 mos., 14 daysHospital, institution, or street address where death occurred: Mt. WilsonBranch, Md. T. B. SanatoriumHow long in hospital or institution? 4 mos., 14 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CecilCity or town Elkton  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. #5  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Martha Rebecca Holmes

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Raymond Holmes6. (c) If alive, give age 38 years

## 7. Birth date of

deceased (mo., day, yr.) May 30, 1926

## 8. AGE:

Years

22

Months

0

Days

4

If less than one day

hrs.

min.

## 9. Birthplace

Elkton, Maryland  
(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

FATHER

12. Name George Bullock13. Birthplace Elkton, Maryland

MOTHER

14. Maiden name Ida Sempers15. Birthplace Elkton, Maryland

## 16. Informant

Mrs. Martha Rebecca HolmesAddress R.F.D. #5, Elkton, Cecil Co., Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 5, 1948  
(month) (day) (year)Cemetery or crematory Elkton CemeteryLocation Elkton, Maryland

## 18. Funeral director

H.W. Pippen & SonAddress Elkton, Maryland

## 19.

6/3/  
(Date rec'd by registrar)1948Walter R. Mayer  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 3, 1948, 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 20, 1948, to June 3, 1948and that I last saw h. er alive on June 3, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

2 1/2 yrs.Due to Tubercle Bacilli

Due to

Other conditions Tuberculous Laryngitis5 mos.

(Include pregnancy within 8 months of death)

No operation

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

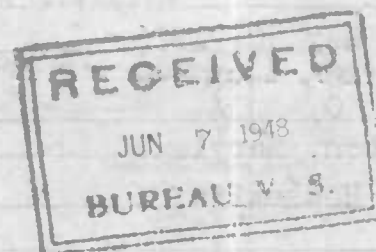
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Stewart S. Shaffer  
M. D. or otherAddress Mt. Wilson, Md. Date signed 6/3/48





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 months  
Hospital, institution, or street address where death occurred:  
Spring Grove Hospital  
How long in hospital or institution? 5 months 23 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Balt. City  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 731 S Hanover St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war ✓

### 3. (a) FULL NAME

Mabel Huntley

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
6. (b) Name of husband or wife Frederick Huntley  
6. (c) If alive, give age (d) years  
7. Birth date of deceased (mo., day, yr.) February 10, 1883  
8. AGE: Years 65 Months 3 Days 24 If less than one day hrs. min.

9. Birthplace Maryland  
(Town, county, and state)  
10. Usual occupation hlf-practical nurse  
11. Industry or business -  
FATHER 12. Name John R. Warfield  
13. Birthplace Maryland  
MOTHER 14. Maiden name Sarah Smith  
15. Birthplace Delaware

16. Informant Mrs. Flossie Frazier  
Address 311 E Hamburg St. Balt.  
17. Burial Date thereof June 6, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Greenlawn Cemetery  
Location Cambridge, Md  
18. Funeral director John F. Henry, Inc  
Address 715 Light St  
19. 6-4-48 Registrar Public  
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 3 19 48 at 4:15 AM  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 11 19 47 to June 3 19 48  
and that I last saw her alive on June 2 19 48  
Immediate cause of death Acute Myocardial Failure  
Due to Hypertensive Cardio-vascular disease  
Due to Diabetes  
Other conditions Diabetes  
(Include pregnancy within 3 months of death)

### DURATION

1 hr

hrs

hrs

Major findings of operations -  
Date of op. -  
Autopsy results -  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide - Date of -  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Isador Tuerk Injured at work?  
23. SIGNATURE Isadore Tuerk M. D. or other  
Address Spring Grove State Hosp. Date signed June 3/48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A16

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PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, be sure to state correct age and sex, and especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 year, 12 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 1 year, 12 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Anne Arundel  
 City or town Weems Creek  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Thomas C. Jacobs

## 3. (b) Social Security Number

-

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Emma

7. Birth date of deceased (mo., day, yr.) April 16, 1870  
 6.(c) If alive, give age 2 years

8. AGE: Years 78 Months 2 Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Maryland  
(Town, county, and state)10. Usual occupation none11. Industry or business none12. Name Thomas Jacobs13. Birthplace unk.14. Maiden name unk.15. Birthplace unk.16. Informant Hospital RecordsAddress Catonsville 28, Md.17. Burial Date thereof 6-24-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Spring Grove State HospitalLocation Catonsville 28, Maryland18. Funeral director Spring Grove State HospitalAddress Catonsville 28, Maryland

19. 6-24- 48 V.E. Harry  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 48 at 7:20 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19 \_\_\_\_\_ to \_\_\_\_\_ 19 \_\_\_\_\_

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Due to Cardiac failureDue to Cardiovascular disease

Other conditions \_\_\_\_\_

\_\_\_\_\_

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**RECEIVED**

JUN 26 1948

**BUREAU V. S.**

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **33**

5915

## 1. PLACE OF DEATH:

County **Baltimore**  
 City or town **Owings Mills**  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? **1/7/37 to 6/30/48**  
 Hospital, institution, or street address where death occurred:  
**Rosewood State Training School**  
 How long in hospital or institution? **1/7/37 to 6/30/48**

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State **Maryland** County **Baltimore**  
 City or town **Owings Mills**  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war .....

## 3. (a) FULL NAME

**Charles William Jones**

## 3. (b) Social Security Number

4. Sex **Male** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Single**  
 6. (b) Name of husband or wife .....  
 7. Birth date of deceased (mo., day, yr.) **September 25, 1923** 6. (c) If alive, give age ..... years  
 8. AGE: Years **24** Months **9** Days **5** If less than one day ..... hrs. .... min.

9. Birthplace **Harford County, Md.**  
 (Town, county, and state)  
 10. Usual occupation **Patient at Rosewood**  
 11. Industry or business .....  
 12. Name **Charles Jones**  
 13. Birthplace **Cecil County, Md.**  
 14. Maiden name **Florence Sharon**  
 15. Birthplace **Harford County, Md.**

16. Informant **Institutional Records**  
 Address **Rosewood, Owings Mills, Md.**  
 17. **Burial** Date thereof **7-3-48**  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory **Charlestown Cemetery**  
 Location **Charlestown, Maryland**  
 18. Funeral director **See A. Patterson & Son**  
 Address **Berryville, Maryland**  
 19. **7-2** 19 **48** **new B.E. Line**  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

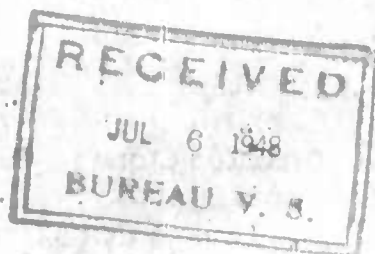
20. DATE OF DEATH **June 30** 19 **48** at **12noon**  
 21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from **1/7/37** 19 **48** to **6/30** 19 **48**  
 and that I last saw him alive on **June 30** 19 **48**  
 Immediate cause of death **Status Epilepticus** DURATION **30 min.**  
 Due to .....  
 Due to .....  
 Other conditions **Little's Disease with symptomatic Epilepsy (Club feet) birth**  
 (Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. ....  
 Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.  
 22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....  
 23. SIGNATURE **H.G. Butler** M.D. or other  
**H.G. Butler, M.D.** M.D. or other  
 Address **Owings Mills, Md.** Date signed **6/30/48**

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Address London, 4-111 Date signed 6/7/4

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE



RECEIVED

JUN 14 1948

BUREAU V. S.

Reg. Dist. No. ....

## 44

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

5918

## 1. PLACE OF DEATH:

County Balto.  
 City or town Reisterstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 yrs  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Balto.  
 City or town Reisterstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 19 Chatsworth Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Gordon Thomas Kay

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife \_\_\_\_\_ 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Sept. 29, 1931  
 8. AGE: Years 16 Months 8 Days 16 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto. Co.  
 (Town, county, and state)  
 10. Usual occupation School boy  
 11. Industry or business \_\_\_\_\_  
 12. Name Harry T. Kay  
 13. Birthplace Balto. Co.  
 14. Maiden name Naomi S. Lockard  
 15. Birthplace Carroll Co.

16. Informant Harry T. Kay  
 Address 19 Chatsworth Ave. Reisterstown  
 17. Burial Date thereof June 18, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory All-Saints  
 Location Reisterstown  
 18. Funeral director J.F. Eline & Sons  
 Address Reisterstown, Md.

19. 6-17-48 Mary B. Eline  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 15 19 48 at 2:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 15 19 48, to June 15 19 48, and that I last saw him on June 16, 1948.

Immediate cause of death Metastatic Sarcoma  
 Due to Sarcoma of L. Femur

Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations Sarcoma of L. Femur  
 Date of op Jan 31, 1948

Autopsy results None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. D. D. Caples Med. Exam.  
Reisterstown, Md. M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 6-17-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County Baltimore Co  
 City or town Overlea  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution? no

## 3. (a) FULL NAME

John H Kilian  
 4. Sex AM 5. Color or race W 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife

Daisy C Kilian

7. Birth date of

deceased (mo., day, yr.)

8. AGE: Years 71 Months 10 Days 29 If less than one day

9. Birthplace

Baltimore and

10. Usual occupation

Retired

11. Industry or business

12. Name Herman Kilian

13. Birthplace

Germany

14. Maiden name

Mary White

15. Birthplace

Germany16. Informant Daisy C KilianAddress 6801 Beach AveBaltimore

17. (Burial, cremation, or removal, Which)

Date thereof 6/4/48Cemetery or crematory Baltimore

Location

18. Funeral director Chas P TowellAddress 2427 Calmoundson Ave6/2 105 A. W. Hedrick19. (Date rec'd by registrar) Dr Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Baltimore Co  
 City or town Overlea  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1801 Beach Ave

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1948 at 730am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 26 1948 to June 1 1948and that I last saw him alive on May 3 1948

Immediate cause of death

Cerebral arteriosclerosis

DURATION

10 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Adam Lewis M. D. or otherAddress 6732 Belair Rd Date signed June 1, 1948

Mr Swins  
6232 Belvoir Rd.  
Hac0034



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

940

5920

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rockdale  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution:  
3610 Eitemiller Road  
 Stay in hospital or inst. (yrs., or mos., or days)  
 Stay in this community (yrs., or mos., or days)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Rockdale Ward No.  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. 3610 Eitemiller Road  
 (If rural give LOCATION)  
 2(e) IF VETERAN, NAME WAR

## 3. (a) FULL NAME

Lorenzo Howard Kirk

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife G. Irene Kirk  
 6(c) If alive, give age 51 years

7. Birth date of deceased (mo., day, yr.) February 23, 1884

8. AGE: Years 64 Months 3 Days 23 If less than one day  
 ----- hrs. ----- min.

9. Birthplace Baltimore County, Md.  
 (Town, county, and state)

10. Usual occupation Farmer & Builder

11. Industry or business Self

12. Name John Kirk

13. Birthplace Baltimore County, Md.

14. Maiden name Charlott Smith

15. Birthplace Randallstown, Md.

16. Informant Mrs. Lorenzo H. Kirk

Address 3610 Eitemiller Rd., Rockdale

17. Burial Date thereof June 21, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Mt. Olive Cemetery

Location Randallstown, Md.

18. Funeral director Thos. L. Lamon

Address 4510 Liberty Heights Ave.

19. June 20, 1948 Date rec'd by registrar  
A. W. Hedrick Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1948, at 8:45 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
6-17-'48 1948, to 6-17-'48 1948  
 and that I last saw him in alive on not seen alive 1948

Immediate cause of death Coronary Artery Disease DURATION  
1 day  
(est.)

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings: NONE

Of operations

Of autopsy

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? NONE  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. D. D. Caples Med. Exam.

6 Hanover Road M. D. or other

Address Reisterstown, Md. Date signed 6-19-48

MARGIN RESERVED FOR BINDING

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## PHYSICIAN

Please underline the cause to which death should be charged statistically.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

5921

44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Balto.City or town Sparrows Point  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1230 Forest Road  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

Mary Lucinda Klein

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Raleigh E. Klein7. Birth date of deceased (mo., day, yr.) March 27 - 18946. (c) If alive, give age 61 years8. AGE: Years 54 Months 2 Days 6 If less than one day  
hrs. min.9. Birthplace Kansas  
(Town, county, and state)10. Usual occupation at home

## 11. Industry or business

12. Name Wm. Sanderson13. Birthplace Kansas14. Maiden name Unknown15. Birthplace Unknown16. Informant Raleigh E. KleinAddress 1230 Forest Rd. Sp. Pt. Md.17. Burial Date thereof June 5 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oak LawnLocation Eastern Boulevard18. Funeral director John G. ConnollyAddress +18 Eastern Ave. East19. June 3 - 1948 Dawson J. Harbes  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 2 - 1948 at 2:50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1 - 1948 to June 2 - 1948and that I last saw him alive on June 2 - 1948

Immediate cause of death

Cardio-respiratory failure 8 hours.Due to Cerebral Embolism 8 hours.Due to Hypertensive Cardio-vascular unknown

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

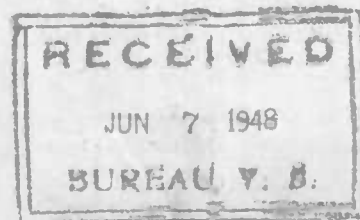
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Robert E. Farber MD M. D. or otherAddress Sparrows Point, Md Date signed 6/3/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5922

830

1. PLACE OF DEATH: Baltimore  
County.....  
City or town..... Westowne  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 5 Yrs.  
Hospital, institution, or street address where death occurred:  
Hood Nursing Home  
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Md. County..... Baltimore  
City or town..... Westowne  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 5313 Edmondson Ave.,  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3.(a) FULL NAME  
Flora M. Kline

3.(b) Social Security Number  
---

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or ~~husband~~ William G. Kline

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) June 23, 1882

8. AGE: Years 66 Months 0 Days 7 If less than one day  
..... hrs. .... min.

9. Birthplace..... Dayton, Ohio  
(Town, county, and state)

10. Usual occupation..... At Home

11. Industry or business.....

12. Name..... William Routzahn

13. Birthplace..... Ohio

14. Maiden name..... Cornelia Poffenberger

15. Birthplace..... Ohio

16. Informant..... Mr. Guy M. Kline

Address..... 2921 Dunmurry Rd. Dundalk, Md.

17. Burial Date thereof..... 7-3-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... Loudon Park

Location..... Baltimore, Md.

18. Funeral director..... J. Howard Strong

Address..... 3207 W. North Ave.,

19. 7-2 19 48 VE Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 30, 48 at P. 4.45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 18 to June 30 48  
and that I last saw him alive on June 30 48

Immediate cause of death..... Cerebral Hemorrhage DURATION 3 Days

Due to..... Arterio Sclerosis

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

Signature..... James Howard M. D. or other

Address..... Chesapeake Date signed..... 7-2

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

RECEIVED

JUL 6 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year, 4 months, 4 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 1 year, 4 months, 4 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County .....  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ?  
(If rural, give LOCATION)  
2. (a) If veteran, name war .....

### 3. (a) FULL NAME

Knust, Herman

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Helen Harris

7. Birth date of deceased (mo., day, yr.) December 8, 1874 6. (c) If alive, give age ..... years

8. AGE: Years 73 Months 6 Days 11 If less than one day ..... hrs. .... min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Painter

11. Industry or business Painting

12. Name Carl Knust

13. Birthplace Germany

14. Maiden name Amelia Wentzel

15. Birthplace Poland

16. Informant Hospital records

Address Catonsville-28, Maryland

17. Burial Date thereof 6/22/48  
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory London Park

Location Balto. Md.

18. Funeral director William Cook Inc.

Address 1217 St. Paul St.

19. June 21, 1948 A. W. Heguesch  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 48 at 9:05 p. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 15 19 47, to June 19 19 48  
and that I last saw him alive on June 19 19 48

Immediate cause of death Coronary occlusion DURATION sudden

Due to Arteriosclerotic heart disease indefinite

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Sudden Fall Injured at work?

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 6-20-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully and legibly. is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5924

44

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Fort Howard  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 Days  
 Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
 How long in hospital or institution? 5 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County...  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 5018 E. Preston St., (Armstead Gardens)  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... WW-I

## 3. (a) FULL NAME

JR.

ANTON J. KOPANSKI (Also known as ANTON J. GRABER)

## 3. (b) Social Security Number

212-09-3772

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Anna Mae Kopanski  
 7. Birth date of deceased (mo., day, yr.) 6-16-1899 6.(c) If alive, give age 45 years  
 8. AGE: Years 49 Months 0 Days 7 If less than one day  
 ..... hrs. .... min.

9. Birthplace Wilmington, Del.  
 (Town, county, and state)

10. Usual occupation Chauffeur

11. Industry or business

FATHER 12. Name Anthony Kopanski  
 13. Birthplace Germany  
 MOTHER 14. Maiden name Frances Drombowski  
 15. Birthplace Germany

16. Informant Clinical Records, Vets. Adm. Hospital  
 Address Fort Howard, Maryland

17. Burial Date thereof 6/25/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Baltimore National Cemetery  
Baltimore, Maryland  
 Location Howard Blight, Funeral Home  
4914 Belair Rd., Balto., Md.  
 18. Funeral director  
 Address

19. 6/24/48  
 (Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23, 19 48 at 7:55 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 18, 19 48 to June 23, 19 48  
 and that I last saw him alive on June 23, 19 48

Immediate cause of death  
Perforated duodenal ulcer

DURATION  
Sudden

Due to.....

Due to.....

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH M.D. Chief Pro. Services.Address VAH, Ft. Howard, Md. Date signed 6-23-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5925

38

## 1. PLACE OF DEATH:

County BALTO.  
 City or town TOWSON # 4-516 Wilton Rd.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD. County BALTIMORE  
 City or town BALTIMORE  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1316 N. BENTLOU ST.  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

CAROLINE THOMAS LAIR

## 3. (b) Social Security Number

No

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

MARRIED

6.(b) Name of husband or wife

HORACE WATERS LAIR (SR)

6.(c) If alive, give age years

7. Birth date of

deceased (mo., day, yr.)

OCT. 5, 1869

8. AGE:

Years

Months

Days

If less than one day

78815

hrs.

min.

9. Birthplace

BALTO. MD.

(Town, county, and state)

10. Usual occupation

HOUSEWIFE

11. Industry or business

THOMAS DAIRD THOMAS

12. Name

WALE

13. Birthplace

WALE

MOTHER

FATHER

14. Maiden name

JANE DAVIS

15. Birthplace

WALE

16. Informant

MRS. O. S. TRAVERS - (DAUGHTER)

Address

516 WILTON RD., TOWSON (A) MD

17. Burial

BURIAL

Date thereof

6/23/48

(Burial, cremation, or removal. Which?)

Cemetery or crematory

WOODLAWN

Location

BALTO. CO. MD.

18. Funeral director

Wm. T. TIBBETTS & SONS

Address

BALTO. MD.

19. June 22, 1948

a w. Heluch

(Date rec'd by registrar)

Registral

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 20 19 48, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 19 19 48, to June 20 19 48and that I last saw him alive on June 16 19 48Immediate cause of death Myocardial infarction with  
arteriosclerosis, heart failure  
central embolism

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Walter B. Buck M.D.

M. D. or other

Address 18 E. Eager St Date signed June 21

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5926

44

Reg. Dist. No.

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 10 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution?..... 10 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Baltimore  
City or town..... Baltimore (22)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 227 Baltimore Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... WW-I

### 3. (a) FULL NAME

ROBERT W. LANSBERRY (Also known as LANSBURY)

### 3. (b) Social Security Number

Unknown

4. Sex..... Male  
5. Color or race..... White  
6.(a) Single, married, widowed, or divorced..... Widower

6.(b) Name of husband or wife..... Widower

7. Birth date of deceased (mo., day, yr.)..... 9-28-94  
6.(c) If alive, give age..... years

8. AGE: Years..... 53 Months..... 8 Days..... 19  
If less than one day..... hrs. .... min.

9. Birthplace..... West Virginia  
(Town, county, and state)

10. Usual occupation..... Unemployed

11. Industry or business

FATHER 12. Name..... Edna Kizner  
13. Birthplace..... Kentucky

MOTHER 14. Maiden name..... William Lansberry  
15. Birthplace..... England

16. Informant..... Clinical Records, Vets. Adm. Hospital  
Address..... Fort Howard, Maryland

17. Removal..... 6-17-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory..... Rose Hill Cemetery  
Location..... Dale Duncan  
Thomas, West Virginia  
Howard Blight

18. Funeral director..... Howard Blight  
Address..... 4914 Belair Rd., Balto., Md.

19. Date rec'd by registrar..... June 17 - 48  
Registrar..... James L. Harber

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 17, 1948 at 8:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 7, 1948 to June 17, 1948  
and that I last saw him alive on June 17, 1948

Immediate cause of death..... SILICOSIS AND TUBERCULOSIS  
DURATION..... Unknown

Due to.....

Due to.....

Other conditions..... None

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy result..... Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... P.C. Newnam, M.D.  
A.C. NEWNAM, M.D. M. D. or other

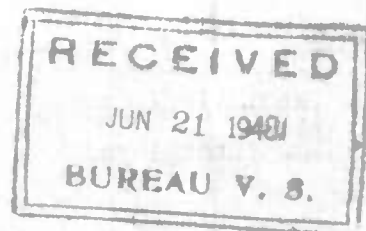
Address..... VAH, Fort Howard, Md. Date signed..... June 17 - 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 43

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fullerton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? life  
Hospital, institution, or street address where death occurred:  
  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
City or town Fullerton, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 7509 Belair Rd.  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

AUGUST H. LASSAHN

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 8.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife Anna K.

7. Birth date of deceased (mo., day, yr.) Jan. 27th, 1868 6.(c) If alive, give age years

8. AGE: Years 80 Months 4 Days 21 If less than one day hrs. min.

9. Birthplace Baltimore County, Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Hardware Dealer

12. Name Carl Lassahn

13. Birthplace Germany

14. Maiden name Caroline Paul

15. Birthplace Germany

16. Informant Mrs. A.H. Lassahn  
Address 7509 Belair Rd.

17. burial Date thereof 6/27/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Immanuel Lutheran

Location Baltimore, Md.

18. Funeral director Lassahn Funeral Home

Address 7401 Belair Rd.

19. July June 19-48 Registrar Mo. G.L. Reiskinder  
(Date rec'd by Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th, 1948 at 7:10 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7, 1946, to 6/18, 1948

and that I last saw him alive on 6/17, 1948

Immediate cause of death Coronary Thrombosis DURATION

Due to Arteriosclerotic changes -

vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. J. Battaglia M.D. M. D. or other

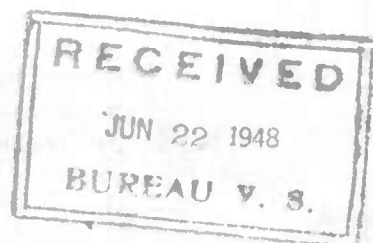
Address 5829 Belair Rd. Date signed 6/18/48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 22 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County BALTIMORE

City or town CATONSVILLE  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: OPITZ NURSING HOME

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County

City or town BALTIMORE  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 752 RESERVOIR ST  
(If rural, give LOCATION)

2.(a) If veteran, name war No

### 3. (a) FULL NAME

JOHN F. LEAMAN

### 3. (b) Social Security Number

218-09-9366

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

SINGLE

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

5/9/1965

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

83

1

19

hrs.

min.

9. Birthplace

MONTGOMERY CO, MD.  
(Town, county, and state)

10. Usual occupation

RETIRED

11. Industry or business

FATHER

12. Name

HEZEKIAH LEAMAN

13. Birthplace

MD.

MOTHER

14. Maiden name

VIRGINIA DOWDEN

15. Birthplace

Va.

16. Informant

Miss ROBERTA LEAMAN (SISTER)

Address

752 RESERVOIR ST.

17.

BURIAL  
(Burial, cremation, or removal. Which?)

Date thereof

7/1/48  
(month) (day) (year)

Cemetery or crematory

FOREST OAK

Location

CATHERSBURG, MD.

18. Funeral director

Wm J. TINKER & SONS

Address

BALTO. MD.

19.

2/1  
(Date rec'd by registrar)

19

48

D.W. Hedrick  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

6/28

19

48 at 12:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-10

19

48

to

6-28

19

48

and that I last saw him alive on

6-28

19

48

Immediate cause of death

Coronary Heart Disease

DURATION

2 days

Due to

Arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address

Catonville

Date signed

6/30

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. **31**

### 1. PLACE OF DEATH:

County **Baltimore**  
City or town **Woodbrook**  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? **9 months**  
Hospital, institution, or street address where death occurred **Merry Villa**  
How long in hospital or institution? **9 months**

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
State **md** County **none**  
City or town **Baltimore City**  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. **5935 York Rd.**  
(If rural, give LOCATION)  
2. (a) If veteran, name war **None**

### 3. (a) FULL NAME

**Anna Macruder McPleave**

### 3. (b) Social Security Number

**none**

4. Sex **Female** 5. Color or race **White** 6. (a) Single, married, widowed, or divorced **Widow**  
6. (b) Name of husband or wife **John McPleave**  
6. (c) If alive, give age **77** years  
7. Birth date of deceased (mo., day, yr.) **Nov-21-1860**

8. AGE: Years **87** Months **7** Days **5** It less than one day **hrs.** min.

9. Birthplace **Hoffman Mines, Md.**  
(Town, county, and state)

10. Usual occupation **none**

11. Industry or business **none**

12. Name **Orlando D. Robbins**

13. Birthplace **Alexandria, Va.**

14. Maiden name **Fanny Schley Macruder**

15. Birthplace **Cumberland, Md.**

16. Informant **Mr. Martha R. Locking (sister)**

Address **3405 Greenway - Baltimore**

17. Burial (Burial, cremation, or removal, Which?) **Burial** Date thereof **June-29-48**  
(month) (day) (year)

Cemetery or crematory **Rose Hill**

Location **Cumberland, Md.**

18. Funeral director **Stewart Memorial**

Address **108 W. York Ave.**

19. **6/28/48** (Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH **June 26** 19 **48**, at **5:00** P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from **June** 19 **47** to **June** 19 **48**

and that I last saw him alive on **June 26** 19 **48**

Immediate cause of death **Anterior subarachnoid hemorrhage**

Due to **Arteriosclerosis Cordis**

Other conditions **Coronary Artery**

(Include pregnancy within 3 months of death)

Major findings of operations **none** Date of op. **none**

Autopsy results **none**

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide **none** Date of **none**

Where did injury occur? **none** (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) **none**

Means of injury **none** Injured at work? **none**

23. SIGNATURE **William G. Helfrich** M. D. or other **none**

Address **5006 Roland Ave.** Date signed **June 28, 1948**

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

5930

61

1. PLACE OF DEATH:  
 County..... Balto.  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
41 Overbrook Road  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State..... Md. County..... Balto.  
 City or town..... Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... 41 Overbrook Rd.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

EMERSON LELAND MCCOY

## 3. (b) Social Security Number

4. Sex..... male  
 5. Color or race..... white  
 6.(a) Single, married, widowed, or divorced..... married  
 6.(b) Name of husband or wife..... Gwendolyn Garrison McCoy  
 6.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.)..... July 24, 1890  
 8. AGE: Years..... 57 Months..... 10 Days..... 29 It less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Salesman  
 11. Industry or business.....  
 FATHER  
 12. Name..... Robert McCoy  
 13. Birthplace..... Balto., Md.  
 MOTHER  
 14. Maiden name..... Helena Thomas  
 15. Birthplace..... Catonsville, Md.

16. Informant..... Mrs. Gwendolyn Garrison McCoy  
 Address..... 41 Overbrook Rd., Catonsville, Md.

17. Burial..... Date thereof..... 6/26/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Western Cem.  
 Location..... Balto., Md.

18. Funeral director..... WM. J. TICKNER & SONS  
 Address..... Balto., Md.

19. 6/26 19 48 SW Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 23, 19 48 at 6:50a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 7 19 48 to June 23 19 48 and that I last saw him alive on June 22 19 48

Immediate cause of death..... Acute Coronary Thrombosis DURATION 1 1/2 hrs.

Due to..... Coronary Atherosclerosis 4 years.

Due to.....

Other conditions..... Diabetes Mellitus 4 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE..... William K. Gallagher M.D. M. D. or other

Address..... Catonsville 28, Md. Date signed 6-24-48

MARGIN RESERVED FOR BINDING

VS A15 9-43-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5931

EX

## 1. PLACE OF DEATH:

County BaltimoreCity or town Port Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 16 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 16 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 532 Wynoke Rd.

(If rural, give LOCATION)

2. (a) If veteran, name war SAW & WW-I

## 3. (a) FULL NAME

~~JOSEPH P. McGINN~~JOSEPH PATRICK MCGINN

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Jodie M. McGinn

## 7. Birth date of deceased (mo., day, yr.)

7-23-776. (c) If alive, give age 61 years

## 8. AGE:

Years 70Months 10Days 8

If less than one day

hrs. min.

## 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

## 10. Usual occupation

Unemployed RETIRED CHIEF

## 11. Industry or business

BALTO FIRE DEPT.

## FATHER

## 12. Name

Thomas McGinn

## 13. Birthplace

Ireland

## MOTHER

## 14. Maiden name

JULIA HAGEN

## 15. Birthplace

Baltimore, Maryland HARFORD CO. MD

## 16. Informant

JODIE M. MCGINN

## Address

532 WYNOKE AVE

## 17.

(Burial, cremation, or removal. Which?)

Burial

## Date thereof

6/17/48

## Cemetery or crematory

Baltimore National Cemetery

## Location

Baltimore, Maryland

## 18. Funeral director

Wm. J. Tickner + SONS

## Address

BALTO, MD

## 19.

(Date rec'd by registrar)

19

6-54819Regist

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2, 1948, 8:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 17, 1948, to June 2, 1948and that I last saw him alive on June 2, 1948

Immediate cause of death

Coronary occlusion with infarction of the heart

DURATION

Unknown

Due to

Due to

Other conditions Severe arteriosclerosisUnknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

H.C. MANAUGH

H.C. MANAUGH, M.D. Chf. Prof. Services

Address VAH, Fort Howard, Maryland Date signed 6-3-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5932

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Baltimore  
 City or town apt 82 Oaklee Village  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Baltimore  
 City or town Oaklee apt village  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 82  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

James Cecil Mc Guire

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Elizabeth A. Anderson B.(c) If alive, give age..... years  
 7. Birth date of deceased (mo., day, yr.) 12-9-1904  
 8. AGE: Years 43 Months 6 Days 16 If less than one day  
 hrs. min.

9. Birthplace Baltimore  
 (Town, county, and state)  
 10. Usual occupation Plumber  
 11. Industry or business Sanitation Brewery  
 12. Name Grant McGuire  
 13. Birthplace MD  
 14. Maiden name Catherine Holligan  
 15. Birthplace Baltimore  
 16. Informant Mrs J.C. McGuire  
 Address 82 Oaklee Village  
 17. Buried Date thereof 6-25-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory London Park  
 Location Federate Ave  
 18. Funeral director John J. Fahey, Inc.  
 Address 1318 Light St  
 19. June 25 48 E. Kieffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 25 48 1948 at 6 a M  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19....., to 19.....  
 and that I last saw him..... alive on 19.....

Immediate cause of death..... DURATION  
Acute Cardiac failure  
 Due to.....  
Subarachnoid Hemorrhage  
 Due to.....  
 Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....  
 Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of Injury Injured at work?  
 23. SIGNATURE Geo. M. Kieffer Examined  
 M. D. or other  
 Address 1010 Lehigh Ave Date signed 6-25-48

**RECEIVED**

JUN 28 1948

**BUREAU V. S.**



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5933

Reg. Dist. No. 42

## 1. PLACE OF DEATH:

County Balto  
 City or town Halters  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred  
Humphreys Bld  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State md County Balto  
 City or town Halters  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 414 Wash. Blvd  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war

## 3. (a) FULL NAME

Harry J McKean

## 3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 12 1891 6. (c) If alive, give age..... years

8. AGE: Years 57 Months 2 Days 4 If less than one day  
 hrs. min.

9. Birthplace Balto md  
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name John J McKean13. Birthplace Balto md14. Maiden name Sarah J Cullen15. Birthplace Balto md16. Informant Frank R McKeanAddress 414 Wash. Blvd17. Burial Date thereof 7-1-48  
 (Burial, cremation, or removal Which?) (month) (day) (year)Cemetery or crematory Int OlivetLocation Fredrick Rd18. Funeral director Edwin ToulsonAddress 2359 Wash Blvd19. June 28 48 De Kieffer  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1948 at 1 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death

Cardiacacute heart failure

Due to

Cardiac vascular disease

Due to

Myocarditis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury injured at work?

23. SIGNATURE De Kieffer Edwin ToulsonAddress 1010 Reedson Date signed 6-28-48

RECEIVED

JUL 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully, in the correct place, and especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5934

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 months, 13 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 5 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore-18  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3708 Eilerslie Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Howard S. McLain

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Elizabeth Gray  
 6.(c) If alive, give age 59 years  
 7. Birth date of deceased (mo., day, yr.) November 23, 1879  
 8. AGE: Years 68 Months 7 Days 6 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Pennsylvania  
 (Town, county, and state)  
 10. Usual occupation Steel worker  
 11. Industry or business Retired  
 12. Name Robert F. McLain  
 13. Birthplace Pennsylvania  
 14. Maiden name Martha Wood  
 15. Birthplace Pennsylvania

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof 7/5/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Meadowridge Memorial Park  
 Location Dorsey, Md.

18. Funeral director William J. Tickner & Sons  
 Address North & Pa. Aves.  
Baltimore, Md.

19. 7/1 19 48 Dr. W. H. H. H. H.  
 (Date rec'd by registrar) (Year) (Signature) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 29 19 48 at 10:20 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 to June 29 19 48  
 and that I last saw him alive on June 29 19 48  
 Immediate cause of death \_\_\_\_\_

Pulmonary oedema  
 Due to \_\_\_\_\_  
Generalized arteriosclerosis  
 Due to \_\_\_\_\_  
fracture left hip  
 Other conditions interlobar pneumonia  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

As above Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide accident Date of June 18, 48  
 Where did injury occur? Catonsville, Balt. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) hospital  
 Means of injury fall out of bed Injured at work? no  
Dr. W. H. H. H. H.  
 23. SIGNATURE Dr. W. H. H. H. H. M. D. or other \_\_\_\_\_  
 Address 1010 Leeds av Date signed 6-30-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 0 yrs., 9 mos., 27 days  
 Hospital, institution, or street address where death occurred Mt. Wilson Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 0 yrs., 9 mos., 27 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore City 21  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 309 511 S. Bouldin Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

August Joseph Meek

## 3. (b) Social Security Number

213-07-4997

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Josephine F. Meek6. (c) If alive, give age 45 years

## 7. Birth date of

deceased (mo., day, yr.) September 5, 1902

## 8. AGE:

Years

45

Months

8

Days

28

If less than one day

\_\_\_\_ hr. \_\_\_\_ min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Carpenter

## 11. Industry or business

FATHER 12. Name Joseph Meek13. Birthplace Austria

## MOTHER

14. Maiden name Josephine Gunzelman15. Birthplace Baltimore, Maryland16. Informant August Joseph MeekAddress 511 S. Bouldin St., Balto., Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof June 5, 1948  
(month) (day) (year)Cemetery or crematory Sacred Heart CemeteryLocation Hermanhill Rd., Dundalk, Md.18. Funeral director John G. ConnellyAddress 418 Eastern Ave., Balto., Md.19. 6/2/48  
(Date rec'd by registrar)

19

Helen R. Mayer  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 2, 1948 4:20 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 6, 47 to June 2, 1948and that I last saw him alive on June 2, 1948

Immediate cause of death

Pulmonary Tuberculosis

DURATION

1 yr.Due to Tubercle Bacilli

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations No operation

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

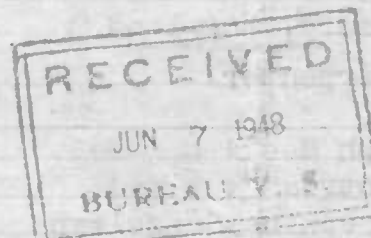
Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE

Stewart S. Shaffer  
M. D. or otherAddress Mt. Wilson, Md. Date signed 6/2/48



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5935

Reg. Dist. No. 42

### 1. PLACE OF DEATH:

County Balto  
City or town Lansdowne  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
417 5th ave

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Balto  
City or town Lansdowne  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 417 5th ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Anna Amalie Meyer

### 3. (b) Social Security Number

4. Sex 7 5. Color or race W 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Herman Meyer

7. Birth date of deceased (mo., day, yr.) June 12 1864 6.(c) If alive, give age 19 years

8. AGE: Years 84 Months 0 Days 5 If less than one day hrs. min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name August Goehbert

13. Birthplace Germany

14. Maiden name Hannelta Goehbert

15. Birthplace Germany

16. Informant Mrs. Galato Meyer

Address 417 5th ave

17. Burial Date thereof June 19 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Lansdowne

Location Balto to md

18. Funeral director Mr. J. Tichner & Son

Address Wm. & Penn ave

19. June 19 48 Ch. Keffen  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 17 1948 at 2:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19 and that I last saw him alive on 19

Immediate cause of death

Acute Cardiac Failure

Due to Coronary vascular disease

Due to fracture left arm

Other conditions at elbow

accident

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accident Date of May 16 48

Where did injury occur? Lansdowne Balto md  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) home

Means of injury fall on floor Injured at work? no

Signature Dr. M. Keffen Ch. Keffen

Address 1010 Leeds ave Date signed June 19 48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 21 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5937

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Since November 1, 1945

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? Since November 1, 1945

## 3. (a) FULL NAME

Katie Mickala (Katrina MIKAILA)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 110 Albemarle Street  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## 4. Sex

F

## 5. Color or race

W

## 6. (a) Single, married, widowed, or divorced

widow

## 8. (b) Name of husband or wife

Anthony MIKAILA7. Birth date of deceased (mo., day, yr.) 1883

6. (c) If alive, give age..... years

## 8. AGE:

Years

Months

Days

If less than one day

65??

hrs.

min.

## 9. Birthplace

Lithuania

(Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

HomeFATHER  
MOTHER12. Name George JONECKIS13. Birthplace Lithuania14. Maiden name Barbara GOJINSKIS15. Birthplace Lithuania

## 16. Informant

Hospital records

## Address

Spring Grove State Hospital

## 17.

Burial  
(Burial, cremation, or removal. Which?)

Date thereof.

6/26/48  
(month) (day) (year)

## Cemetery or crematory

Sole Redeemer

## Location

Baltimore Md

## 18. Funeral director

## Address

637 Wash. Blvd.

## 19.

6-24-  
(Date rec'd by registrar)19 48V.E. Harvey

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 23rd, 1948 19..... at 6:50 PM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
November 1, 1945 19..... to June 23, 1948 19.....and that I last saw her alive on June 23, 1948 19.....

## Immediate cause of death

Cerebral accident

## DURATION

1/2 hourDue to Hypertensive C. V. D. diseaseindefGeneralized arterio-sclerosisindefDue to Residual right hemiplegiaindef

## Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations left ovarian cyst/1946Date of op. August 30/

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) .....

Means of injury

Injured at work?

## 23. SIGNATURE

Abraham M. Schneider  
Abraham M. Schneider, M. D.

## Address

Spring Grove Hospital

## Date signed

6-23-48

RECEIVED

JUN 26 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County... Baltimore  
 City or town... Reisterstown, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? December 4, 1947  
 Hospital, institution, or street address where death occurred:  
Mt. Pleasant Sanatorium, Reisterstown, Md.  
 How long in hospital or institution? December 4, 1947

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County...  
 City or town... Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1542 Appleton St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war... ☒

## 3. (a) FULL NAME

HARRY MILLMAN

## 3. (b) Social Security Number

213-05-4588

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife Ester  
 7. Birth date of deceased (mo., day, yr.) March 8, 1875 6.(c) If alive, give age... years  
 8. AGE: Years 73 Months 3 Days 8 If less than one day  
 ...hrs. ...min.

9. Birthplace... Russia  
 (Town, county, and state)  
 10. Usual occupation... Tailor  
 11. Industry or business

FATHER 12. Name... Kunny MILLMAN  
 13. Birthplace... Russia  
 14. Maiden name... Rosie  
 15. Birthplace... Russia

MOTHER 16. Informant... Morton Millman  
 Address... 1542 Appleton St.

17. Burial Date thereof... 6-18-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Mt. Carmel  
 Location... German Hill Ref.

18. Funeral director... Frank Lewis, Inc.  
 Address... 2100 Eutaw Place

19. June 18, 1948 AW Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 18, 1948 at 2:15 A.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
December 4, 1947 to June 18, 1948  
 and that I last saw him alive on June 18, 1948  
 Immediate cause of death... Myocardial Collapse  
 Due to... Pulmonary Tuberculosis  
bilateral, far advanced  
 Due to...  
 Other conditions...  
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... Cecil Rudner MD  
 M. D. or other  
Mt. Pleasant Sanatorium Date signed June 18, 48  
Reisterstown, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information fully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 9yrs

Hospital, institution, or street address where death occurred:

Spring Grove State HospitalHow long in hospital or institution? 9yrs 5months2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Maryland County Balt.City or town Baltimore City  
(If outside city or town limits, write RURAL and give nearest town)Street No. 111 Grindall St.  
(If rural, give LOCATION)2.(a) If veteran, name war — ✓

## 3. (a) FULL NAME

Robert E. Moran

## 3. (b) Social Security Number

None

## 4. Sex

male

## 5. Color or race

white

## 6. (a) Single, married, widowed, or divorced

widowed6. (b) Name of husband or wife Mary Liz Craig7. Birth date of deceased (mo., day, yr.) Dec. 11, 1871.8. AGE: Years 76, Months 5 Days 21. If less than one day — hrs. — min.9. Birthplace Anne Arundel Co. Maryland  
(Town, county, and state)10. Usual occupation Farm hand11. Industry or business —12. Name George W. Moran13. Birthplace Anne Arundel Co. Md.14. Maiden name Mary Standsbury15. Birthplace Anne Arundel Co. Md.16. Informant Edward MoranAddress 111 Grindall St. Balt.17. Burial Date thereof June 5, 1948  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory St. Ann's ParkLocation Anne Arundel County18. Funeral director A. J. EvansAddress 1400 S. Charles St.19. 6-4 48 Registrar —  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 1948 at 7 p. m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1939 to May 2 1948and that I last saw him live on May 2 1948

Immediate cause of death

Hypertensive Cardio-vascular diseaseDue to Generalized ArteriosclerosisDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) (County) (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE Isadore Tuerk M. D. or other —Address Spring Grove Hospital Date signed May 2/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5940

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hosp. Fort Howard, Md.How long in hospital or institution? 4 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2506 Madison Ave.  
(If rural, give LOCATION)2. (a) If veteran, name war WW-1

## 3. (a) FULL NAME

OTIS MORS

## 3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

Negro

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Florence Mors6. (c) If alive, give age 45 years7. Birth date of deceased (mo., day, yr.) March 6, 1891

8. AGE: Years Months Days If less than one day

57326

hrs. min.

9. Birthplace Matthews County, Va.  
(Town, county, and state)10. Usual occupation unemployed

11. Industry or business

12. Name William Mors13. Birthplace Virginia14. Maiden name May Mors15. Birthplace Virginia16. Informant Clinical Records Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial (Burial, cremation, or removal. Which?) Date thereof 6/30/48  
(month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation 5501 Frederick Ave. Balto. Md.18. Funeral director Charles R. LawAddress 802 Madison Ave. Balto. Md.19. 6/29 48 Atto Medical  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 26 1948 at 1:35A M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 22 1948 to June 26 1948and that I last saw him alive on June 26 1948Immediate cause of death Cerebral infarct

DURATION

5 days

Due to

Due to

Other conditions Infarct of Right Kidney 5 days

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Green M. D. or otherAddress VAH Ft. Howard, Md. Date signed 6-26-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

5941

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Fort Howard, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

V.A. H. Fort Howard, MarylandHow long in hospital or institution? 12 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)Street No. None 309 Sharp St.  
 (If rural, give LOCATION)2.(a) If veteran, name war WWI

## 3. (a) FULL NAME

MUHLNFELD, Fred J.

## 3. (b) Social Security Number

unknown

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Divorced6. (b) Name of husband or wife divorced6. (c) If alive, give age        years7. Birth date of deceased (mo., day, yr.) 8/15/95

8. AGE:	Years	Months	Days	It less than one day
	<u>52</u>	<u>10</u>	<u>5</u>	<u>      </u> hrs. <u>      </u> min.

9. Birthplace Baltimore-Maryland  
 (Town, county, and state)10. Usual occupation unemployed

## 11. Industry or business

12. Name Otto Muhlenfeld13. Birthplace Maryland14. Maiden name Julia Mack15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. Hospital  
 Address Fort Howard, Maryland17. Burial        Date thereof 6/23/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetary or crematory Holy Redeemer  
 Location Belair Road, Balto-Md.18. Funeral director Lilly & Zeiler  
 Address 403 S. Wolfe St. Balto-Md.19. June 21 19 48 A. V. Delucia  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 48 at 3:28 AM21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 8 19 48 to June 20 19 48 and that I last saw him alive on June 20 19 48Immediate cause of death PULMONARY TUBERCULOSIS  
FAR ADVANCEDDURATION unknownDue to       Due to       Other conditions       

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op.       Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide        Date of       Where did injury occur?        (City or town)        (County)        (State)Injured at home, farm, industry, public place (where?)       Means of injury        Injured at work?       23. SIGNATURE Richard L. Delucia  
V.A. H. Ft. Howard, Md. M. D. or other 6/20/48Address        Date signed

Evidence from C.D. The report:

2112 Jefferson St.

309 Sharp St. from relative L. 7/8/48.  
deceased to undertaker. a.s.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5942

13/2

### 1. PLACE OF DEATH:

County Balto

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Balto

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 N. Rolling Rd.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife Charles L. Neuman

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years 91 Months 7 Days 21 If less than one day  
hrs. min.

9. Birthplace Germany  
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Michael Huff

13. Birthplace Germany

14. Maiden name Julia A. Summehelt

15. Birthplace Germany

16. Informant Mrs. Myrtle G. Gripe

Address 16 N. Rolling Rd.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 6-29-48  
(month) (day) (year)

Cemetery or crematory Salem Lutheran

Location Ingleside Ave. Catonsville

18. Funeral director Wm. Cook Inc.

Address 1217 St. Paul St.

19. 6/29 XX A. W. Hedrick  
(Date rec'd by registrar) Registrar

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH 6-27 19 48 at 6 0 0 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6-17 19 48 to 6-27 19 48

and that I last saw h. et alive on 6-27 19 48

Immediate cause of death Pulmonary Infarction DURATION 7 days

Due to Myocardial ?

Due to Cardio-vascular renal dis. ?

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE George E. Urban M. D. or other

Address 803 3rd Ave Date signed 6-27-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

5943

456

## 1. PLACE OF DEATH:

County Balto.City or town Ruxton  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Malvern Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Ruxton  
(If outside city or town limits, write RURAL and give nearest town)Street No. Malvern Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

ROBERT NEWELL

## 3. (b) Social Security Number

4. Sex male	5. Color or race white	6. (a) Single, married, widowed, or divorced widowed
----------------	---------------------------	---

6. (b) Name of husband or wife Rose A. Newell7. Birth date of deceased (mo., day, yr.) Aug. 8, 1863

8. AGE:	Years	Months	Days	It less than one day
84	10	0	hrs.	min.

9. Birthplace Scotland  
(Town, county, and state)10. Usual occupation Retired Police11. Industry or business Balto. City12. Name Unknown

13. Birthplace

14. Maiden name Unknown

15. Birthplace

16. Informant Mrs. Mae N. LongAddress Malvern Ave., Ruxton, Md.17. Cremation Date thereof 6/9/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Greenmount CrematoryLocation Balto., Md.18. Funeral director WM. J. TIEKNER & SONSAddress Balto., Md.19. 6-9 48  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 8, 1948 at 1:45 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 7, 1948 to June 7, 1948 and that I last saw him alive on June 8, 1948

Immediate cause of death

Carcinoma Tongue

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Thos. H. GreenAddress Baltimore, Md.Date signed 6/9/48

M. D. or other

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

119 Clarendon Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Pikesville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 126 Slade Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Elizabeth Oler

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Richard C. Oler

6. (c) If alive, give age ..... years

7. Birth date of

deceased (mo., day, yr.) April 22, 1878

8. AGE:

Years

Months

Days

If less than one day

70113

hrs.

min.

9. Birthplace Baltimore County, Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

FATHER

12. Name Julius Arndt13. Birthplace Germany

MOTHER

14. Maiden name Amelia Kreeger15. Birthplace Germany16. Informant Mr. Richard C. OlerAddress 126 Slade Ave., Pikesville, Md.17. Burial Date thereof June 8, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Druid Ridge CemeteryLocation Pikesville, Md.18. Funeral director W. L. AmoranAddress 4510 Liberty Heights Ave.19. June 7, 1948  
(Date rec'd by registrar)19. 48A. W. Hedger  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 19..... at 9.55A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 25 19 47, to June 5 19 48  
and that I last saw h er alive on June 4 19 48

Immediate cause of death

Carcinoma stomach

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

Address 1735 Poplar Grove St.

Date signed

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5945

Reg. Dist. No. XX

### 1. PLACE OF DEATH:

County Baltimore  
City or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 6 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Md.  
How long in hospital or institution? 6 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County A.A.  
City or town Harwood  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war WW I ✓

### 3. (a) FULL NAME

DANIEL OWENS

### 3. (b) Social Security Number

Unknown

4. Sex Male 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Marie Owens  
6.(c) If alive, give age 48 years  
7. Birth date of deceased (mo., day, yr.) 8-20-95  
8. AGE: Years 52 Months 10 Days 8 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Bristol, Maryland  
(Town, county, and state)

10. Usual occupation Farmer

### 11. Industry or business

FATHER 12. Name Thomas Owen  
13. Birthplace Anne Arundel Co., Md.

MOTHER 14. Maiden name Lizzie Evans  
15. Birthplace Anne Arundel Co., Md.

16. Informant Clinical Records, Vets. Adm. Hosp.  
Address Fort Howard, Maryland

17. Burial Burial Date thereof 7-1-48  
(Burial, cremation, or removal, Which?) (month) (day) (year)  
Cemetery or crematory Bristol, Maryland  
Location \_\_\_\_\_

18. Funeral director Charles R. Law  
Address 802 Madison Ave., Balto., Md.

19. 6/29 1948 AW Hedrick  
(Date rec'd by registrar) (Registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1948 6:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 22, 1948 to June 22, 1948 and that I last saw him alive on June 28, 1948

Immediate cause of death Hypertrophy left ventricle.  
History of hypertension

DURATION  
5 Yrs.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions None

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results Substantiated Above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H.C. MANAUGH  
H.C. MANAUGH, M.D. Chief Professional

Address VAH, Ft. Howard, Md. Ser. 6-28-48  
Date signed \_\_\_\_\_

MARGIN RESERVED FOR BINDING

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Grott

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

## 1. PLACE OF DEATH:

County ParkvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

2201 Taylor Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County ParkvilleCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2201 Taylor Avenue  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Paul A. Payne

## 3. (b) Social Security Number

218-09-9383

4. Sex

male

5. Color or race

white

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife Lily (Lillie) Payne

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dec. 20, 18718. AGE: Years 76 Months 5 Days 13 If less than one day  
hrs. min.9. Birthplace North Carolina

(Town, county, and state)

10. Usual occupation Night Watchman11. Industry or business Baltimore, Life Bldg.12. Name George Payne13. Birthplace ?14. Maiden name Sarah Dunn15. Birthplace ?16. Informant Mrs. Lillie PayneAddress 2201 Taylor Avenue17. Burial Date thereof 6-5-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Baltimore18. Funeral director Leonard J. RuckAddress 5305 Harford Road #1419. 6-2 19 48 Dr. Grott  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2nd 19 48, at 11:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

5/18/48 19 48 to 6/2 19 48  
and that I last saw him alive on 6/2 19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

2 1/2 hrs

Due to

Generalized arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Harold A. Grott M. D. or otherAddress 8100 Harford Rd Date signed 6/2/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 33

## 1. PLACE OF DEATH:

County BaltimoreCity or town Glyndon  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 50 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltoCity or town Glyndon  
(If outside city or town limits, write RURAL and give nearest town)Street No. 17 Belle View Ave.  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Carrie E. Penn

## 3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 12, 18898. AGE: Years Months Days It less than one day  
59 23 hrs. min.9. Birthplace Balto. Co.  
(Town, county, and state)10. Usual occupation Clerk in Post Office

11. Industry or business

12. Name George W. Penn13. Birthplace Balto. Co.14. Maiden name Emma McCaulley15. Birthplace Baltimore City16. Informant Mrs. Herbert M. ScotneyAddress Glyndon, Md.17. Burial Date thereof June 7, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory All-Saints CemeteryLocation Reisterstown, Md.18. Funeral director J. F. Eline & SonsAddress Reisterstown, Md.19. 6-7- 19 48 Mary B. Eline  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5 19 48 at 8:30 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1-25- 19 37 to 6-5- 19 48and that I last saw her alive on 6-4- 19 48Immediate cause of death Carcinoma of Breast DURATION 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. D. Caples M.D. M. D. or otherAddress Reisterstown, Md. Date signed 6-4-48



RECEIVED

JUN 9 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5948

## 1. PLACE OF DEATH:

County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 months 21 days

Hospital, institution, or street address where death occurred:

Spring Grove State Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1716 North Durham Street  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Michael Della Penna

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Julia Della Penna6. (c) If alive, give age 46 years

## 7. Birth date of

deceased (mo., day, yr.)

April 13, 1887

## 8. AGE:

Years

Months

Days

If less than one day

61214

hrs.

min.

## 9. Birthplace

Italy

(Town, county, and state)

## 10. Usual occupation

Bricklayer

## 11. Industry or business

Construction

## FATHER

12. Name Anthony Della Penna13. Birthplace Italy

## MOTHER

14. Maiden name Lucia Churta15. Birthplace Italy

## 16. Informant

Hospital RecordsAddress Catonsville, 28, Maryland

## 17.

(Burial, cremation, or removal, Which?)

Date thereof

Burial July 1, 1948  
(month) (day) (year)

Cemetery or crematory

Holy Redeemers

Location

Belair Road

## 18. Funeral director

Wendell J. Shippel

Address

3125 - Highland Ave

## 19.

(Date rec'd by registrar)

6/30 1948 Dr. [Signature]  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 19..... at 1:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to 19.....

and that I last saw him alive on 19.....

Immediate cause of death

DURATION

Subarachnoid hemorrhage

Due to

Therapeutic malarsia

Due to

Obesity & hypertension

Other conditions

Syphilis  
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. or other

[Signature] 1010 Reckman 6-27-48  
Address Date signed

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

<b>1. PLACE OF DEATH</b> County <u>Balto.</u> City or town <u>Long Green</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death <u>60 years</u> Hospital, institution, or street address where death occurred: _____ How long in hospital or institution? _____				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>md</u> County <u>Balto.</u> City or town <u>Long Green</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) 2(a) If veteran, name war _____			
<b>3. (a) FULL NAME</b> <u>Lellie B. Phillips</u>				<b>3. (b) Social Security Number</b> _____			
<b>4. Sex</b> <u>Female</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widow</u>			
<b>6. (b) Name of husband or wife</b> <u>John A. Phillips</u>							
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 28 1872</u>							
<b>8. AGE:</b> Years <u>75</u> Months <u>18</u> Days <u>27</u>		<b>6. (c) If alive, give age</b> _____ years _____ hrs. _____ min.					
<b>9. Birthplace</b> <u>Lovell Knot Tenn.</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Home maker</u>							
<b>11. Industry or business</b> <u>Joseph Miller</u>							
<b>12. Name</b> <u>Joseph Miller</u>							
<b>13. Birthplace</b> <u>Lancaster Pa.</u>							
<b>14. Maiden name</b> <u>Rebecca Zook</u>							
<b>15. Birthplace</b> <u>Pa.</u>							
<b>16. Informant</b> <u>Frank E. Phillips</u> Address <u>Long Green Md.</u> <u>Burke</u>							
<b>17. (Burial, cremation, or removal, which?)</b> Date thereof <u>JUNE 7 1948</u> (month) (day) (year) Cemetery or crematory <u>Wilsons</u> Location <u>Long Green Md.</u>							
<b>18. Funeral director</b> <u>Henry M. Jenkins &amp; Sons Co.</u> Address <u>Mc Culloch Orchard St</u>							
<b>19. (Date rec'd by registrar)</b> <u>6/7/48</u> Registrar <u>A. W. Hefner</u>							

<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>June 5</u> , 19 <u>48</u> , at <u>2:45</u> P.M. <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>June</u> , 19 <u>46</u> , to <u>June 5</u> , 19 <u>48</u> , and that I last saw her alive on <u>June 4</u> , 19 <u>48</u> . Immediate cause of death <u>Coronary</u> <u>Heart Failure</u> DURATION <u>3 mo.</u> Due to <u>Hypertensive Cardiovascular disease</u> <u>6 years</u> Due to _____ Other conditions <u>None</u> (Include pregnancy within 3 months of death) Major findings of operations <u>None</u> Date of op. _____ Autopsy results _____ PHYSICIAN: Please underline the cause to which death should be charged statistically.	
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____ <b>23. SIGNATURE</b> <u>Charles E. Jeff</u> M.D. or other _____ Address <u>Street, Md.</u> Date signed <u>June 6, 1948</u>	

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

## 1. PLACE OF DEATH:

County Baltimore  
City or town Essex  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 days

Hospital, institution, or street address where death occurred:

Ivy Nursing HomeHow long in hospital or institution? 7 days2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)State Md CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1003 E. Oliver St.

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

MARY LORETTO POPP

## 3. (b) Social Security Number

139-03-2530

## 4. Sex

Female

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

single

## 6.(b) Name of husband or wife

6.(c) If alive, give age years

## 7. Birth date of

deceased (mo., day, yr.)

Oct. 29. 1884

## 8. AGE:

Years

63

Months

7

Days

13

If less than one day

hrs. min.

## 8. Birthplace

Baltimore

(Town, county, and state)

## 10. Usual occupation

Maid, Chambre

## 11. Industry or business

Marlborough-Blenheim Hotel

## FATHER

## 12. Name

George Popp

## 13. Birthplace

Baltimore

## MOTHER

## 14. Maiden name

Katherine Seward

## 15. Birthplace

Baltimore

## 16. Informant

Mr. William R. Pohler

## Address

3015 Alameda Blvd.

## 17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof June 15. 1948  
(month) (day) (year)

## Cemetery or crematory

Greenmount Cemetery

## Location

Baltimore Md.

## 18. Funeral director

HENRY SANDER & SONS, INC.

## Address

Baltimore Md.

## 19.

(Date rec'd by registrar)

6/1445A. W. Hedrick  
Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 12. 1948 at 7.00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 15 1948 to June 12 1948  
and that I last saw h. er alive on June 8 1948Immediate cause of death HADGKINS DISEASE

## DURATION

5 yr.

Due to

Due to

Other conditions

Arteriosclerosis  
Chronic vascular disease  
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Manner of injury Injured at work?

23. SIGNATURE

John S. Blum

M. D. or other

Address

115 N. Calver St

Date signed

6/14/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 mo. 10 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 1 mo. 10 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Balt. City  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3919 Southern Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war.       

### 3. (a) FULL NAME

Peter Pulkert

### 3. (b) Social Security Number

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed  
6.(b) Name of husband or wife Barbara  
7. Birth date of deceased (mo., day, yr.) December 13 1867 6.(c) If alive, give age (d) years  
8. AGE: Years 80 Months 6 Days 3 It less than one day        hrs.        min.

9. Birthplace Austria (Town, county, and state)  
10. Usual occupation brewery worker  
11. Industry or business         
FATHER 12. Name         
13. Birthplace         
MOTHER 14. Maiden name         
15. Birthplace       

16. Informant Mrs Marie McDowell (daughter)  
Address 3919 Southern Ave.  
17. Burial Date thereof 6/19/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Most Holy Redeemer Church  
4430 Belair Road  
Location Howard N. Blight Jr.  
18. Funeral director Howard N. Blight Jr.  
Address 4914 Belair Road  
19. June 18 1948 A.W. Hyslop  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 16 19 48 at 5:50 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 6 19 48 to June 16 19 48  
and that I last saw in alive on June 16 19 48

Immediate cause of death Bronchopneumonia, rt. base DURATION 12 hrs.

Due to Arteriosclerotic heart disease yrs  
Due to Generalized arteriosclerosis yrs  
Other conditions       

(Include pregnancy within 3 months of death)

Major findings of operations        Date of op.       

Autopsy results         
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide        Date of         
Where did injury occur?        (City or town)        (County)        (State)

Injured at home, farm, industry, public place (where?)         
Means of injury        Injured at work?       

23. SIGNATURE Isadore Tuerk M. D. or other         
Spring Grove Hospital Date signed June 26/48  
Address       

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Indicate correct age as especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5952

Reg. Dist. No. 41

## 1. PLACE OF DEATH

County BaltoCity or town Dundalk 22  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date received by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

Address

Date signed



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County... Baltimore  
City or town... Cockeysville (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?... Lifetime  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Baltimore  
City or town... Cockeysville (Rural)  
(If outside city or town limits, write RURAL and give nearest town)  
Street No... Powers Ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war...

### 3. (a) FULL NAME

Georgianna Randolph

### 3. (b) Social Security Number

4. Sex... F. 5. Color or race... Colored 6. (a) Single, married, widowed, or divorced... married

6. (b) Name of husband or wife... William Randolph

6. (c) If alive, give age... years  
7. Birth date of deceased (mo., day, yr.)... Dec. 16, 1880

8. AGE: Years... 67 Months... 6 Days... 6 If less than one day... hrs. min.

9. Birthplace... Cockeysville, Md.  
(Town, county, and state)

10. Usual occupation... Housewife

11. Industry or business

12. Name... James Payne

13. Birthplace... Cockeysville, Md.

14. Maiden name... Elizabeth Johnson

15. Birthplace... Balls Bl. Md.

16. Informant... William Randolph  
Address... Cockeysville, Md.

17. Burial Date thereof... June 25, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory... Basil Chapel  
Cockeysville, Md.

18. Funeral director... Samson M. Bwafis  
Address... Sparks, Md.

19. 6-23 48 Wilmer C. Ensor  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH... 22 June 48 at 7:10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1946 to 22 June 48  
and that I last saw him alive on 22 June 48

Immediate cause of death... Cerebral Vascular accident DURATION... 1 day

Due to... Hypertension 6 1/2 yrs.

Due to... Arteriosclerosis ?

Other conditions... Cardiac decompensation 1 year

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

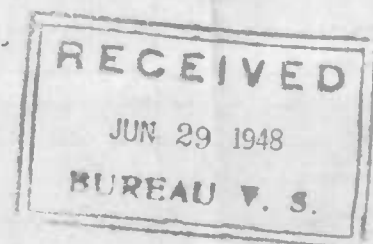
23. SIGNATURE... Walter T. Kees M.D.  
M. D. or other

Address... Cockeysville, Md. Date signed... 6-22-48

MARGIN RESERVED FOR BINDING

VS A15 9.43.15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5954

950

Reg. Dist. No. 37

### 1. PLACE OF DEATH:

County Baltimore  
City or town Cockeysville Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 16 months  
Hospital, institution, or street address where death occurred:  
Masonic Home  
How long in hospital or institution? 16 months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Md County Montgomery  
City or town Cherry Chase Ind  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 4713 De Russay Parkway  
(If rural, give LOCATION)  
2.(a) If veteran, name war ☒

### 3. (a) FULL NAME

Joseph Reading  
4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widower  
6.(b) Name of husband or wife Mary F. Cassaway  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) Sept. 13 - 1850  
8. AGE: Years 97 Months 9 Days 5 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 19 19 48 at 10:50 P. M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 48 to June 19 19 48 and that I last saw him alive on June 19 19 48  
Immediate cause of death Terminal Bronchial Pneumonia DURATION 1 day  
Due to Arterial Sclerosis about 4 yrs  
Due to Cardiac Hypertrophy  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Walter T. Kees M.D. M. D. or other \_\_\_\_\_  
Address Cockeysville Md Date signed 6/19/48

9. Birthplace Flemington N. J. (town, county, and state)  
10. Usual occupation Farmer last job Postmaster  
11. Industry or business \_\_\_\_\_  
12. Name Wm. Reading  
13. Birthplace Flemington N. J.  
14. Maiden name Sarah Matilda Capner  
15. Birthplace Flemington N. J.  
16. Informant Laura M. Schradler  
Address Masonic Home, Cockeysville Md  
17. Burial Date thereof June 22 - 48  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Rockville Union  
Location Rockville Md.  
18. Funeral director Wm. Cook  
Address St. Paul & Preston St  
19. 6/21 19 48 Laura M. Schradler  
(Date rec'd by registrar) Registrar

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 22 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

5955

93d

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 867 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 867 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 2922 Boarman Avenue  
(If rural, give LOCATION)2. (a) If veteran, name war SAW

## 3. (a) FULL NAME

MILTON H. REID

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Laura Reid7. Birth date of deceased (mo., day, yr.) March 4, 1877 6. (c) If alive, give age 57 years8. AGE: Years 71 Months 3 Days 0 If less than one day  
hrs. min.9. Birthplace Virginia  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Lee Grant Reid13. Birthplace VirginiaMOTHER 14. Maiden name Huldy Fairfax15. Birthplace Virginia16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Md.17. Removal June 4, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hall Funeral HomeLocation Occoquan, Va.18. Funeral director Howard M. Blight, Jr.Address 4914 Belair Rd. Balto., Md.19. June 7 19 48 Lawrence P. Parker  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 48 at 11:05 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
January 19 19 46 to June 4 19 48  
and that I last saw him alive on June 4 19 48Immediate cause of death CEREBRAL VASCULAR  
ACCIDENTDue to Hypertensive Cardio Vascular  
Disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Morris Bursleson M. D. or otherAddress VAH, Fort Howard, Md. Date signed 6/4/48

M. D. or other

RECEIVED

JUN 10 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH *Re*  
2411 N. Charles St., Baltimore  
138  
**CERTIFICATE OF DEATH**

5956

Reg. Dist. No. *44***1. PLACE OF DEATH:**

County Baltimore  
City or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 Days  
Hospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, Maryland  
How long in hospital or institution? 10 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)  
State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 803 S. Dallas St.  
(If rural, give LOCATION)  
2.(a) If veteran, name war WWI ☒

**3. (a) FULL NAME**HOWARD REPP**3. (b) Social Security Number**Unknown

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife Single  
6.(c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) 3-13-89  
8. AGE: Years 59 Months 3 Days 0 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Maryland  
(Town, county, and state)

10. Usual occupation Unemployed

**11. Industry or business**

FATHER 12. Name Leonard Repp  
13. Birthplace Maryland

MOTHER 14. Maiden name Mary Stumpner  
15. Birthplace Maryland

16. Informant Clinical Records, Vets. Adm. Hosp.

Address Fort Howard, Md.

17. Burial Date thereof 6/15/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Baltimore National Cemetery

Location Frederick Ave. Baltimore, Md.  
Howard N. Blight Jr.

18. Funeral director Blight Funeral Home

Address 4914 Belair Rd. Baltimore, Maryland

19. 6/15 x 8 A.W. Hedrick  
(Date rec'd by registrar) (month) (day) (year) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH June 13 19 48 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 3 19 48 to June 13 19 48 and that I last saw him alive on June 13 19 48

Immediate cause of death Pulmonary Tuberculosis DURATION Unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE H.C. Manaugh

H.C. MANAUGH, M.D. Chief Professional Ser.

Address VAH, Ft. Howard, Md. Date signed 6-14-48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

5957

93d

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard, Maryland  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 daysHospital, institution, or street address where death occurred:  
Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 6 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltoCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 1208 - 63rd Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW-1

## 3. (a) FULL NAME

CLINTON C. RILEY

## 3. (b) Social Security Number

Unknown

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

MaleWhiteMarried6. (b) Name of husband or wife Barbara Riley6. (c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) 2/29/968. AGE: Years Months Days If less than one day  
52 3 12 hrs. min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Unemployed

11. Industry or business

12. Name William Riley13. Birthplace Baltimore, Maryland14. Maiden name Anna Clinton15. Birthplace Baltimore, Maryland16. Informant Clinical Records, Vets. Adm. Hospital  
Address Fort Howard, Maryland17. Burial Date thereof 6-14-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Oaklawn CemeteryLocation Baltimore, Maryland18. Funeral director Roland F. HerrAddress Belair Road & Kentucky Avenue Balto., Md.19. 6/11/48 6/11/48 6/11/48  
(Date rec'd by registrar) (Date signed by registrar) (Date signed by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 48 at 6:00 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
June 5, 19 48 to June 11, 19 48  
and that I last saw him alive on June 11, 19 48Immediate cause of death  
Myocardial failure

DURATION

6 daysDue to Myocardial infarction6 daysDue to Arteriosclerotic heart disease7 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. MANAUGH, Chf. Prof. ServicesAddress VAH, Fort Howard, Md. Date signed 6/11/48

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

52a

5958

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Balto.City or town Bloomfield  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

3322 Washington Rd

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County BaltoCity or town Bloomfield  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3322 Washington Rd  
(If rural, give LOCATION)

2.(a) If veteran, name war .....

## 3. (a) FULL NAME

Martha May Roberts

## 3. (b) Social Security Number

217-22-6301

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife

Benjamin W. Roberts

7. Birth date of deceased (mo., day, yr.)

Jan 17<sup>th</sup> 1887

8. AGE: Years Months Days it less than one day

61 5 1 hrs. min.

9. Birthplace

Balto. Md.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

Kopfers Co

12. Name

John M. Garber

13. Birthplace

Balto. Co. Md.

14. Maiden name

Sarah E. Meyers

15. Birthplace

Balto. Co. Md.

16. Informant

Mrs Sarah E. Stubbins

Address

3322 Washington Blvd

17. (Burial, cremation, or removal, which?) Date thereof (month) (day) (year)

Burial 6/21/48

Cemetery or crematory

London Park

Location

Balto. Md.

18. Funeral director

William Cook Inc.

Address

1217 St. Paul St

19. (Type rec'd by registrar)

June 21 19 48 A. W. Hedrick  
J Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 19 48 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 23 19 48 to June 18 19 48and that I last saw h. ER alive on June 18 19 48

Immediate cause of death

Hypernephromaof pathway withDue to multiple metastases

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations .....

..... Date of op. ....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide, .....

Where did injury occur? .....

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE .....

Address 2411 Washington Blvd Date signed 6/18/48

MARGIN RESERVED FOR BINDING

VS-A15 9-45-15M

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct use of this form is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex Female 5. Color or race White 6. (c) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19. 6-23

19 48

V.E. Harry

(Date rec'd by registrar)

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

June 23, 1948

at 11:20 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Nov 6, 1947

to June 22, 1948

and that I last saw her alive on June 16, 1948

Immediate cause of death

Coronary Artery Disease

Due to

Cardio-Renal Vascular

Due to

None

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Address

Date signed

RECEIVED

JUN 26 1948

BUFFALO, N. Y.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

5960

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Parkville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 16 yrs.  
 Hospital, institution, or street address where death occurred:  
3016 Taylor Ave.  
 How long in hospital or institution? - -

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Baltimore  
 City or town Parkville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3016 Taylor Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

CLAUDE SANBURY

## 3. (b) Social Security Number

212-16-3053

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Ida M. Wolf  
 6.(c) If alive, give age 72 years  
 7. Birth date of deceased (mo., day, yr.) Oct. 10. 1871  
 8. AGE: Years 76 Months 7 Days 25 If less than one day hrs. min.

9. Birthplace Annapolis Md.  
 (Town, county, and state)  
 10. Usual occupation Machinist - retired  
 11. Industry or business  
 FATHER 12. Name Richard Sansbury  
 13. Birthplace Maryland  
 MOTHER 14. Maiden name Sarah Raennolds  
 15. Birthplace Maryland

16. Informant Mrs. Ida M. Sansbury (Wife)  
 Address 3016 Taylor Avenue -14

17. Burial Date thereof June 8, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Western Cemetery  
 Location Baltimore Md.

18. Funeral director HENRY SANDER & SONS, INC.  
 Address Baltimore Md.

19. June 8 19 48 A. W. Hedrick  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 at 11.30 A.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 20 19 48 to June 5 19 48  
 and that I last saw him alive on June 4 19 48

Immediate cause of death

DURATION

Cerebral hemorrhageDue to arteriosclerotic (VD)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Harold A. Grotte, M.D. M. D. or otherAddress 8100 Harford Rd Date signed 6/5/48

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coroner's age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5961

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 10 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 21 N. Carey Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I

## 3. (a) FULL NAME

GEORGE H. SAUERS

## 3. (b) Social Security Number

Unknown 213-10-8730

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widower6. (b) Name of husband or wife Widower7. Birth date of deceased (mo., day, yr.) 10-10-90

6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

57818hrs.min.9. Birthplace Baltimore, Maryland  
(Town, county, and state)10. Usual occupation Unemployed11. Industry or business Samuel Dell Co.12. Name George Sauers13. Birthplace Germany14. Maiden name Lillian Huffman15. Birthplace Unknown16. Informant Clinical Records, Vets. Adm. H. sp.Address Fort Howard, Maryland17. Burial Date thereof 7-2-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Louden Park Cemetery,Baltimore, MarylandLocation George A. Schwal18. Funeral director Schwal Funeral HomeAddress Baltimore, Maryland19. 7/1 48 RW Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 19 48, at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 18, 19 48, to June 28, 19 48and that I last saw him alive on June 28, 19 48Immediate cause of death Pulmonary Tuberculosis

DURATION

Unknown

Due to

Due to

Other conditions None

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Substantiated Above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H.C. Manauh RJDH.C. MANAUGH, M.D. Chief of P.O. ServicesAddress VAH, Ft. Howard, Md. Date signed 6-29-48

PLEASE WRITE PLAINLY, WITH FADING INK. Supply every item of information fully and correctly. It is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 months, 19 days  
 Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
 How long in hospital or institution? 7 months, 19 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1712 Guilford Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Nellie Sauers

## 3. (b) Social Security Number

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed  
 6. (b) Name of husband or wife Nicholas J. Sauers  
 7. Birth date of deceased (mo., day, yr.) November 6, 1867  
 6. (c) If alive, give age        years  
 8. AGE: Years 80 Months 6 Days 29 If less than one day        hrs.        min.

9. Birthplace New York  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Home  
 12. Name John Collins  
 13. Birthplace England  
 14. Maiden name Nellie ?  
 15. Birthplace England

16. Informant Hospital records  
 Address Catonsville-28, Maryland  
 17. Burial Date thereof 6/7/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or ~~crematory~~ Holy Redeemer  
 Location Balto. Md.  
 18. Funeral director William Cook Inc.  
 Address 1217 St. Paul St.  
 19. 6-5 19 48 Wm Cook  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 4 19 48 at 12:05 pm

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from        19        to        19         
 and that I last saw him        alive on        19       

Immediate cause of death Bronch Pneumonia  
 Due to fracture of left femur  
 Due to accident  
 Other conditions         
 (Include pregnancy within 3 months of death)

Major findings of operations        Date of op.       

Autopsy results         
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Accident Date of May 8, 48  
 Where did injury occur? Catonsville Balto. Md.  
 (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) hospital  
 Means of injury fall out of bed Injured at work? no  
 23. SIGNATURE Geo. W. Kieffer M. D. or other         
 Address 1010 Leaden Date signed 6-4-48

1948  
80  

---

1868

1948-18-30  
1867-11-6  

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80-6-28



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 28 years, 6 months, 8 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 28 years, 6 months, 8 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ?  
(If rural, give LOCATION)

### 3. (a) FULL NAME

Bessie Snow Sawers

### 3. (b) Social Security Number

4. Sex..... female  
5. Color or race..... white  
6. (a) Single, married, widowed, or divorced..... widowed  
6. (b) Name of husband or wife..... William Brown Sawers  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.)..... July 3, 1879  
8. AGE: Years..... 68 Months..... 11 Days..... 15  
If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore, Maryland  
(Town, county, and state)  
10. Usual occupation..... None  
11. Industry or business..... None  
12. Name..... Thomas F. Snow  
13. Birthplace..... Portsmouth, Virginia  
14. Maiden name..... Olivia Cutherell  
15. Birthplace..... Portsmouth, Virginia

16. Informant..... Hospital records  
Address..... Catonsville-28, Maryland  
17. (Burial, cremation, or removal, Which?)..... Burial Date thereof..... 6-19-48  
(month) (day) (year)  
Cemetery or crematory..... St. Lawrence Park  
Location..... Baltimore Md  
18. Funeral director..... Stewart & Mainville  
Address..... 109 W. North Ave.  
19. 6-18 19 48 W.E. Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18 19 48 at 10:55 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
and that I last saw him..... alive on..... 19.....

Immediate cause of death..... Bronch. Pneumonia  
Due to.....  
Due to..... Subarachnoid  
Cerebral hemorrhage  
Other conditions..... Adipose tissue  
fracture right wrist  
(Include pregnancy within 3 months of death)

Major findings of operations.....  
Date of op.....  
Autopsy results..... as above  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Accident Date of..... 6-15-48  
Where did injury occur?..... Catonsville Baltimore  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)..... Hospital  
Means of injury..... fall on the floor Injured at work? no  
23. SIGNATURE..... W.E. Harry M. D. or other.....  
Address..... 1010 Madison Date signed..... 6-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECEIVED

JUN 21 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## I. PLACE OF BIRTH:

County BaltimoreCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 24 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

## 3. (a) FULL NAME

William Scheufele

## 3. (b) Social Security Number

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife

Johanna

7. Birth date of deceased (mo., day, yr.)

Feb 27, 1868

6. (c) If alive, give age, years

8. AGE:

80 Years3 Months12 Days

If less than one day

9. Birthplace

Baltimore, Co.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Christian

12. Name

William Scheufele

13. Birthplace

Germany

14. Maiden name

Elizabeth (unknown)

15. Birthplace

Germany

16. Informant

Mrs. Johanna Scheufele

Address

334 Stafford Drive

17. (Burial, cremation, or removal, which?)

burial

Date thereof

6/11/48  
(month) (day) (year)

Cemetery or crematory

Meadowdale Cemetery

Location

Stoney Mt.

18. Funeral director

John J. Brown & Son

Address

901-03 Fallis St.

19. ( ) / registrar

6-9-48

Regist.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Baltimore County BaltimoreCity or town Catonville  
(If outside city or town limits, write RURAL and give nearest town)Street No. 334 Stafford Drive  
(If rural, give LOCATION)

2. (a) If veteran, name war

## MEDICAL CERTIFICATION

23. DATE OF DEATH June 8, 1948 at 9:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

27 May 1948 to 8 June 1948and that I last saw him alive on 7 June 1948Immediate cause of death Cardiac Insufficiency DURATION12 hrs.Due to Arteriosclerotic Heart DiseaseDue to Arteriosclerotic Heart DiseaseOther conditions Carcinoma prostate gland

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. Bradley Laughlin, M.D. M. D. or otherAddress 1264 Francis Ave Date signed 6-8-48

MARGIN RESERVED FOR BINDING

VS A16 9-15-13M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 31

## 1. PLACE OF DEATH:

County BaltimoreCity or town Hebbyville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Rolling Road

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Hebbyville  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rolling Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

John Henry Schisler

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Daisy M. Schisler6.(c) If alive, give age 68 years

7. Birth date of

deceased (mo., day, yr.)

August 26, 1878

8. AGE:

Years

Months

Days

If less than one day

6999

hrs.

min.

9. Birthplace Baltimore County, Md.  
(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

Self

FATHER

12. Name Louis Schisler13. Birthplace Maryland

MOTHER

14. Maiden name Catherine Subock15. Birthplace Maryland16. Informant Mrs. Daisy M. SchislerAddress Rolling Road, Hebbyville

17. (Burial, cremation, or removal. Which?)

BurialDate thereof June 7, 1948  
(month) (day) (year)

Cemetery or crematory

Mt. Olive Cemetery

Location

Randalltown, Md.

18. Funeral director

Address

4510 Liberty Heights Ave.

19. (Date rec'd by registrar)

19.

June 7, 1948A. W. Hedrick

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 5, 1948 19. at 2 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15, 1948 to June 5, 1948  
and that I last saw him alive on June 4, 1948

Immediate cause of death

Suppurative infection of hip + femurDue to acute leukemiaDue to spinal sclerosis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. C. Culbert

M. D. or other

Address 4509 Liberty Hgts Ave.Date signed June 5, 1948

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Baltimore (inadequate home)

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 3728 Brooklyn Ave  
(If rural, give LOCATION)2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Mary Heaven Schoun

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

George

7. Birth date of

deceased (mo., day, yr.)

June 20 1864

8.(c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace

Rockhall MD  
(Town, county, and state)Annurife

10. Usual occupation

11. Industry or business

John Stevens

12. Name

13. Birthplace

MD

14. Maiden name

Lorah Goff

15. Birthplace

MD16. Informant Mrs. Martha A. FordAddress 3728 Brooklyn AveBaltimoreDate thereof 6/24/48

(Burial, cremation, or disposal. Which?)

Cemetery or crematory Modern LodgeLocation Baltimore18. Funeral director William GoffAddress 1211 S. Paul St19. June 22 19 48 A. W. Redick

(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 20 19 48 at 7:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 24 19 48 to June 20 19 48and that I last saw him alive on June 19 19 48

Immediate cause of death

Acute myocardial

DURATION

acute

Due to

arteriosclerotic hypertension

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury

Injured at work?

23. SIGNATURE

W. H. Schoun M. D. or otherAddress Baltimore Date signed June 22 19 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. M. B. Green  
Evergreen Ave.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 38

### 1. PLACE OF DEATH:

County Parkville

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

8314 Harford Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Parkville

City or town Baltimore  
(if outside city or town limits, write RURAL and give nearest town)

Street No. 8314 Harford Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Margaret B. Seidl

### 3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced widowed

6.(b) Name of husband or wife John A. Seidl

7. Birth date of deceased (mo., day, yr.) Feb. 2. 1868 8.(c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 80 Months 4 Days 2 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Balto. Co. Md.  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business

12. Name Frank Luskorn

13. Birthplace Germany

14. Maiden name Barbara Nagengast

15. Birthplace Germany

16. Informant Mrs. William Schafer

Address 8314 Harford Road

17. Burial Burial Date thereof 6-7-48  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Joseph

Location Fullerton, Md.

18. Funeral director Leonard J. Ruck

Address 5305 Harford Road #14

19. June 7 1948 A. M. Bacon  
(Date rec'd by registrar) (month) (day) (year) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 4th, 1948 at 12:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 21 1948 to June 4 1948

and that I last saw him alive on June 2 1948

Immediate cause of death Cardiac decompensation DURATION June 2 - 1948  
(Arterio Sclerosis)

Due to Chronic Myocarditis A number of years 1948

Other conditions Chronic Myocarditis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

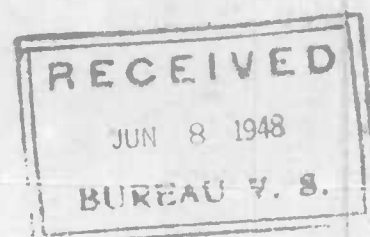
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Morris B. Green M. D. or other \_\_\_\_\_

Address 3009 Euphrasia Ave Date signed 6/5/48  
Balto 14





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County..... Baltimore  
 City or town..... Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 6 Years  
 Hospital, institution, or street address where death occurred:  
 .....  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Pikesville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 3505 Overbrook Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

MARY ELLEN SHEEHAN

## 3. (b) Social Security Number

4. Sex <u>Female</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Single</u>	
6. (b) Name of husband or wife.....			
7. Birth date of deceased (mo., day, yr.) <u>Sept. 17, 1888</u>			
8. AGE: Years <u>59</u>	Months <u>9</u>	Days <u>1</u>	If less than one day ..... hrs. .... min.

9. Birthplace..... Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation..... Stenographer  
 11. Industry or business..... Continental Can Co.  
 FATHER  
 12. Name..... Maurice P. Sheehan  
 13. Birthplace..... Baltimore, Md.  
 MOTHER  
 14. Maiden name..... Mary Ellen Casey  
 15. Birthplace..... England.

16. Informant..... Mrs Anne Casey Jenkins  
 Address..... 414 Southway, Guilford 19

17. Burial..... Date thereof..... 6/21/48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory..... Cathedral  
 Location..... Baltimore, Maryland.

18. Funeral director..... Henry H. Weems and Son  
 Address..... 805 N. Calvert Street

19. 6-19-48 Registrar  
 (Date rec'd by registrar) 19.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 18 1948 at 7:45 A. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 ..... 19....., to..... June 18 1948  
 and that I last saw him..... alive on..... 19.....

Immediate cause of death.....  
Pleural Effusion  
 Due to..... Metastatic Carcinoma Lung  
 Due to..... Carcinoma Breast  
 Other conditions.....

(Include pregnancy within 8 months of death)  
 Major findings of operations..... Carcinoma Breast  
 Date of op. ....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of .....  
 Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Means of injury..... Injured at work?

23. SIGNATURE..... John A. Weems M. D. or other  
 Address..... 1208 E. Main St. Pikesville Date signed..... 6/19/48

718  
1948-8-18

59-9-1

1888-9-17

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of Maryland State Dept. of Health  
 birth date shown on: BALTIMORE CITY HEALTH DEPARTMENT  
 FILM No. G 116 JUN 29 1948 2411 N Charles St. Balto 94a

# CERTIFICATE OF DEATH

Registered No. 38

## 1. PLACE OF DEATH:

(a) Baltimore City, Maryland

(b) Street address Carrollton Ave Ruxton Md(c) Hospital or institution Balto. CountyHow long in above place of death? - Life

(d) Length of stay in hospital or inst. (yrs., mos., or days)

(e) Length of stay in Baltimore (yrs., mos., or days)

## 2. USUAL RESIDENCE OF DECEASED:

(a) State Maryland (b) County Baltimore(c) City or town Ruxton  
(If outside city or town limits, write RURAL and give town)(d) Street No. Carrollton Ave  
(If rural give location)(e) Citizen of foreign country? no (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

Herbert Shipley Herbert Whitmore Shipley

3 (b) If veteran, name war

no

3 (c) Social Security Account

no

4. Sex

m

5. Color or race

white

6 (a) Single, married, widowed, or

divorced.

6 (b) Name of husband or wife Elizabeth (nee Fish)6 (c) If alive, give age 55 years7. Birth date of deceased (mo., day, yr.) April 7, 1885

8. AGE:

Years

Months

Days

If less than one day

6327

hr.

min.

9. Birthplace Balto Co. Md.

(Town, county, and state)

10. Usual Occupation Plumbing & Heating Contractor

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

MOTHER

14. Maiden Name

unknown

15. Birthplace

16 (a) Informant Mrs. H. W. Shipley(b) Address Ruxton, Md.17 (a) Burial (b) Date thereof June 20, 48

(Burial, cremation, or removal) (month) (day) (year)

(c) Cemetery or crematory Prospect Hill Cem.Location Lanham, Md.18 (a) Funeral director Landon M. Brooks(b) Address Sparks, Md.19 (a) June 19, 48 (b) D. L. Kelly Registrar(Date rec'd by registrar) June 19, 48

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th 1948 at 8:45 M21. I certify that death occurred on the date above stated; that I attended deceased from 1935 to June 19, 1948and that I last saw him alive on June 18, 1948

Immediate cause of death

Coronary Thrombosis

Due to

Coronary Artery Disease

Due to

(Recent EKG)

Other Conditions

(Include pregnancy within 3 months of death)

Date of operation

Major findings of operation:

of autopsy:

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide

(b) Date of occurrence at M

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur about home, on farm, industrial place, in public

place? While at work?

(Specify type of place)

(e) Means of injury

23. Signature Nathaniel M. BeckAddress 100 S. 23rd StDate signed June 18, 48

## PHYSICIAN

Underline the cause to which death should be charged statistically.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 48

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 18 days

Hospital, institution, or street address where death occurred:

Veterans Administration HospitalHow long in hospital or institution? 18 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 906 N. Milton Avenue

(If rural, give LOCATION)

2. (a) If veteran, name war WWII

## 3. (a) FULL NAME

WILLIAM J. SKARDA

## 3. (b) Social Security Number

212-05-6819

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Agnes Skarda6. (c) If alive, give age 35 years7. Birth date of deceased (mo., day, yr.) October 31, 19088. AGE: Years 39 Months 7 Days 2 If less than one day  
..... hrs. .... min.9. Birthplace Baltimore, Md.  
(Town, county, and state)10. Usual occupation Turner leader11. Industry or business Rustless Iron & Steel Corp.12. Name John Skarda13. Birthplace Baltimore, Md.14. Maiden name Barbara Pokorny15. Birthplace Baltimore, Md.16. Informant Clinical Records, Vet. Adm. Hosp.Address Fort Howard, Md.17. Burial Date thereof 6/5/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Schimunek Funeral Home, Inc.Address 2601 E. Madison St., Balto. Md.19. June 4 19 48 A. W. Skarda  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 2 19 48 at 2:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 15 19 48, to June 2 19 48and that I last saw him alive on June 2 19 48

Immediate cause of death

CARCINOMA OF STOMACH

DURATION

Unknown

Due to

Due to

Other conditions Dilatation of right side  
of the heart

(Include pregnancy within 3 months of death)

Unknown

Major findings of operations

Date of op.

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE John Skarda M.D.Address Balto Co. Health Officer

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

### 1. PLACE OF DEATH:

County Baltimore

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3.5 yrs

Hospital, institution, or street address where death occurred:

Hilltop Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Hilltop Road  
(If rural, give LOCATION)

2.(a) If veteran, name war

None

### 3. (a) FULL NAME

Harry Stump Skipper

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Battie M. Skipper  
nee Hanson

7. Birth date of deceased (mo., day, yr.) June 3, 1870 6. (c) If alive, give age 64 years

8. AGE: Years 78 Months — Days 10 If less than one day — hrs. — min.

9. Birthplace Maryland  
(Town, county, and state)

10. Usual occupation Chapenter

11. Industry or business Thomas Skipper

12. Name Maryland

13. Birthplace Leak Mill

14. Maiden name Maryland

15. Birthplace Mrs. Battie M. Skipper

16. Informant Hilltop Rd. Catonsville Md.

17. Burial (Burial, cremation, or removal, Which?) June 16, 1948  
(month) (day) (year)

Cemetery or crematory Dover Cemetery

Location Dover Md.

18. Funeral director Easton Sons

Address 608 Frederick Ave Catonsville Md.

19. 6-15 19 48 VE. Harry  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 13, 1948 at 6:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 11 1941, to June 13 1948

and that I last saw him alive on June 13 1948

Immediate cause of death

Chr. Myocarditis

DURATION

3 20

Due to myocarditis 10 yr.

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE William K. Gallager M.D.  
M. D. or other

Address Catonsville 28, Md. Date signed 6-14-48

MARGIN RESERVED FOR BINDING

VS A16

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 17 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5972

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Raspeburg  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

18 Kolb Ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Balto.City or town Raspeburg  
(If outside city or town limits, write RURAL and give nearest town)Street No. 18 Kolb Ave.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

EMMA M. SMITH

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

female white widowed6. (b) Name of husband or wife George J. Smith7. Birth date of deceased (mo., day, yr.) Feb. 4th, 1868 6. (c) If alive, give age years8. AGE: Years Months Days It less than one day  
80 4 14 hrs. min.9. Birthplace Balto., Md.  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Chas. W. Henkel13. Birthplace Balto., Md.14. Maiden name Susanna Biddison15. Birthplace Balto., Md.16. Informant Mrs. Heln M. MoggAddress 18 Kolb Ave., Balto. 6, Md.17. burial Date thereof June 22, 1948  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory ParkwoodLocation Balto., Md.18. Funeral director Lassahn Funeral HomeAddress 7401 Belair Road19. June 19 48 Dr. G. L. Rejsnik  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 18th, 19 48, at 9:20 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 19 46, to June 18 19 48  
and that I last saw him alive on June 18, 19 48

Immediate cause of death

Cerebral hemorrhage

DURATION

4 daysDue to Hypertensive arteriosclerosis  
Heart disease15 years

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Adam G. Lewis

M. D. or other

Address 6232 Belair Rd., Balto 6, Md. Date signed June 19, 1948

**RECEIVED**

**JUN 22 1948**

**BUREAU V. S.**

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore Co.City or town Catonsville Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Les Charles Smith4. Sex M 5. Color or race colored 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Elizabeth Smith7. Birth date of deceased (mo., day, yr.) unknown 18738. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace W. Carolina  
(Town, county, and state)10. Usual occupation on welfare

11. Industry or business

12. Name not known13. Birthplace W. Carolina

14. Maiden name \_\_\_\_\_

15. Birthplace W. Carolina16. Informant Elizabeth SmithAddress Neil Edmondson ave17. Burial Date thereof 6/30/48  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Baltimore Co. Olinth HouseLocation Ex as Baltimore Co.18. Funeral director Edw. J. W. NallyAddress Catonsville Md.19. 6-29 19 48 V.E. Harris  
(Date rec'd by registrar) Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County BaltimoreCity or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2. (c) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28<sup>th</sup> 19 48, at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3-28-48 19 48 to 6-28- 19 48and that I last saw him alive on 6-28-48 19 48

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Mitral Insufficiency P.Hypertensive arteriosclerosisHeart DiseaseOther conditions ArthritisCardiac asthma  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. J. Maloney MDAddress Catonsville Md. M. D. or other \_\_\_\_\_Date signed 6/28/48

1948  
75  
1873

RECEIVED

JUL 2 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 7 Months  
 Hospital, institution, or street address where death occurred:  
Rev. Priest Nursing Home  
 How long in hospital or institution? 7 Months

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Balt.  
 City or town Catonsville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Edmondson Ave.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Harry P. Smith  
 4. Sex M. 5. Color of race W. 6. (a) Single, married, widowed, or divorced Widowed  
 6. (b) Name of husband or wife Jessie F. Smith  
 7. Birth date of deceased (mo., day, yr.) Feb 26, 1868 B. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: 80 Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

2D. DATE OF DEATH June 2 1948 at 6 P. M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 28 1948 to June 2 1948 and that I last saw him alive on June 2 1948  
 Immediate cause of death Cerebral Hemorrhage DURATION 2 days  
Generalized Arteriosclerosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_  
 Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of Injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John A. Moran M. D. or other \_\_\_\_\_  
 Address 3000 E. Balt St Date signed 6/4

9. Birthplace Maryland (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business \_\_\_\_\_  
 12. Name Wm. Smith  
 13. Birthplace Maryland  
 14. Maiden name Ester Ann ?  
 15. Birthplace Maryland  
 18. Informant Mrs. Margaret E. Holloway  
 Address 2402 Hamilton Ave  
 17. Burial Date thereof 6-4-48  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Olivet  
 Location Fredrick Rd  
 18. Funeral director John A. Moran  
 Address 3000 E. Balt St  
 19. 6-3 1948 W.E. Harry  
 (Date rec'd by registrar) Registrar

RECEIVED

JUN 7 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5975

44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 75 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 75 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland CountyCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 750 Ramsay Street  
(If rural, give LOCATION)2.(a) If veteran, name war WW-I ✓

## 3. (a) FULL NAME

EDGAR P. STACK

## 3. (b) Social Security Number

Unknown

## 4. Sex

Male

## 5. Color or race

White

## 6.(a) Single, married, widowed, or divorced

Married--Separated

## 6.(b) Name of husband or wife

Bessie Stack6.(c) If alive, give age ? years

## 7. Birth date of

deceased (mo., day, yr.) 10-31-1892

## 8. AGE:

Years

Months

Days

If less than one day

55721

.....hrs.

.....min.

9. Birthplace Baltimore, Maryland

(Town, county, and state)

10. Usual occupation Unemployed

## 11. Industry or business

Retired Glass Blower

## FATHER

12. Name Robert Stack13. Birthplace Unknown Balto., Md.

## MOTHER

14. Maiden name Julia A. Butler15. Birthplace Maryland (Balto. Co.)16. Informant Clinical Records, Vets. Adm. Hosp.Address Fort Howard, Maryland17. Burial  
(Burial, cremation, or removal. Which?)Date thereof 6/25/48  
(month) (day) (year)Cemetery or crematory New CathedralBalto., Md.

Location

18. Funeral director William Tickner & SonsAddress Penn. & North Ave. Baltimore, Md.19. June 23 48 A. W. Hedrick  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 21, 19 48 10:40P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 7, 19 48 to June 21, 19 48and that I last saw him alive on June 21, 19 48Immediate cause of death MENINGO-ENCEPHALITISOF UNDETERMINED CAUSE.

## DURATION

2 weeks

Due to.....

Due to.....

Other conditions Old Rheumatic Endocarditis ofMitral Valve; pericardial adhesions. UnknownSlight cirrhosis of liver.  
(Include pregnancy within 6 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results Substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE JACK MORROW  
JACK MORROW, M.D.

M. D. or other

Address VAH, Ft. Howard, Md. Date signed 6/22/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

, Reg. Diat. No. 31

## 1. PLACE OF DEATH:

County... BaltimoreCity or town... Randallstown Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?... 40 years

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... BaltimoreCity or town... Randallstown  
(If outside city or town limits, write RURAL and give nearest town)Street No... Liberty Road  
(If rural, give LOCATION)

2(a) If veteran, name war

## 3. (a) FULL NAME

William E. Stang

## 3. (b) Social Security Number

217-03-1347

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Mary C. Stang6. (c) If alive, give age... 63 years7. Birth date of deceased (mo., day, yr.)... March 5, 1888.

## 8. AGE:

60 Years3 Months4 Days

... hrs. min.

9. Birthplace... Randallstown Balto. Co., Md.  
(Town, county, and state)10. Usual occupation... Carpenter11. Industry or business... Builder12. Name... William Howard Stang13. Birthplace... Montgomery Co., Md.14. Maiden name... Agnes Zeigler15. Birthplace... Reville Md.16. Informant... Mrs. Mary C. StangAddress... Randallstown Md.17. Burial Date thereof... June 12, 1948.  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Holy Family CemeteryLocation... Liberty Road, Randallstown, Md.18. Funeral director... Easton SonsAddress... Ellicott City, Maryland.19. 6/10/48 1948 Wm. E. Martin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... June 9, 1948. at 10:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 1, 1948 to June 9, 1948and that I last saw him alive on June 8, 1948Immediate cause of death... Cerebral Embolism

DURATION

Due to... 10 yearsDue to... 10 yearsDue to... 10 yearsDue to... 10 yearsDue to... 10 yearsOther conditions... 10 years

(Include pregnancy within 8 months of death)

Major findings of operations... 10 yearsDate of op. 10 yearsAutopsy results... 10 years

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... 10 years

Where did injury occur? (City or town) (County) (State)

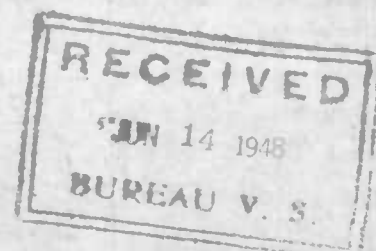
Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... Wm. E. Martin

M. D. or other

Address... Ellicott City, Md. Date signed 6/9/48



MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# BALTIMORE CITY HEALTH DEPARTMENT CERTIFICATE OF DEATH

Registered No. 5077

## 1. PLACE OF DEATH

- (a) Baltimore City, Maryland
- (b) Street address 110 Montrose Ave.
- (c) Hospital or institution: Catonsville
- (d) Length of stay in hospital or inst. (yrs., mos., or days)
- (e) Length of stay in Baltimore (yrs., mos., or days) Life

## 2. USUAL RESIDENCE OF DECEASED:

- (a) State Md. (b) County Baltimore
- (c) City or town Baltimore  
(If outside city or town limits, write RURAL and give town)
- (d) Street No. 110 Montrose Ave.  
(If rural give location)
- (e) Citizen of foreign country? (Yes or No)  
If yes, name country

## 3 (a) FULL NAME

Elizabeth V. Starke

## 3 (b) If veteran, name war

## 3 (c) Social Security Account No.

## 4. Sex

F

## 5. Color or race

W

## 6 (a) Single, married, widowed, or divorced.

married

## 6 (b) Name of husband or wife

Christian J. Starke

## 6 (c) If alive, give age

82 years

## 7. Birth date of deceased (mo., day, yr.)

Nov. 19, 1863

## 8. AGE:

84

Years

Months

Days

If less than one day

hr.

min.

## 9. Birthplace

Baltimore Md.

(Town, county, and state)

## 10. Usual Occupation

Housewife

## 11. Industry or business

FATHER

## 12. Name

Casper Menberth

## 13. Birthplace

Germany

MOTHER

## 14. Maiden Name

Mary Menberth

## 15. Birthplace

Germany

## 16 (a) Informant

Miss Lydia Starke

## (b) Address

110 Montrose Ave.

## 17 (a)

Burial

(b) Date thereof June 5, 1948

(Burial, cremation, or removal)

(month) (day) (year)

## (c) Cemetery or crematory

New Cathedral Cemetery

## Location

Old Frederick Rd.

## 18 (a) Funeral director

Krause Funeral Home

## (b) Address

1216 S. Charles St.

## 19 (a)

6-5-48

(Date rec'd by registrar)

(b) Registrar

(Name) (Signature)

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

June 2, 1948, at 12:45 P.M.

21. I certify that death occurred on the date above stated; that I attended deceased from 19 to 19, and that I last saw her alive on June 2, 1948.

## Immediate cause of death

Lobar Pneumonia

## Duration

1 day

## Due to

## Due to

## Other Conditions

Chronic Myocarditis

(Include pregnancy within 3 months of death)

## Date of operation

## Major findings of operation:

## PHYSICIAN

Underline the cause to which death should be charged statistically.

## of autopsy:

## 22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide
- (b) Date of occurrence at M
- (c) Where did injury occur? (City or town) (County) (State)
- (d) Did injury occur about home, on farm, industrial place, in public place? (Specify type of place) While at work?
- (e) Means of injury

## 23. Signature

Alfred H. Brantner

## Address

4209 2nd Ave

Date signed 6/4/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully, the correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5978

Reg. Dist. No. 43

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Overlea, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 25 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore  
 City or town Overlea, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 6715 Linden Ave.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war Spanish American War

## 3. (a) FULL NAME

ROBERT E. LEE STEUART

## 3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower  
 6. (b) Name of husband or wife Ella Mae  
 7. Birth date of deceased (mo., day, yr.) Jan. 26th, 1864 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 84 Months 4 Days 25 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Baltimore, Md.  
 (Town, county, and state)  
 10. Usual occupation Machinist  
 11. Industry or business \_\_\_\_\_

12. Name Samuel Steuart  
 13. Birthplace Unknown  
 14. Maiden name Limmer  
 15. Birthplace Unknown

16. Informant Mr. Rieman Michel  
 Address 6713 Linden Ave.,  
 17. burial Date thereof 6/24/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory Parkwood  
 Location Baltimore, Md.

18. Funeral director Lassahn Funeral Home  
 Address 7401 Belair Rd.

19. June 22 1948 Jose A. I. Riosonides  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 21st, 19 48 at 1:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from October 19 48 to June 21 19 48  
 and that I last saw him alive on June 21 19 48

Immediate cause of death Uremia DURATION 2 wks

Due to Carcinoma of sigmoid 9 months

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Stephen A. Van Lill M.D.  
2843 St Paul St M. D. or other \_\_\_\_\_  
 Address \_\_\_\_\_ Date signed 6-22-48

RECEIVED

JUL 2 1948

BUREAU V. S.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... 3 mos. 9 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution?..... 3 mos. 9 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Anne Arundel  
City or town..... Orchard Beach  
(If outside city or town limits, write RURAL and give nearest town)  
Street No.....  
(If rural, give LOCATION)  
2.(a) If veteran, name war..... ☒

### 3. (a) FULL NAME

Frank Streb

### 3. (b) Social Security Number

4. Sex..... M 5. Color or race..... W 6.(a) Single, married, widowed, or divorced..... Widowed

6.(b) Name of husband or wife..... Ella McComas Streb  
6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)..... May, 16, 1865  
8. AGE: Years..... 83 Months..... 12 Days..... 17 If less than one day..... hrs. .... min.

9. Birthplace..... Baltimore  
(Town, county, and state)

10. Usual occupation..... Garbage Collector

11. Industry or business..... Public

12. Name..... George Streb  
13. Birthplace..... Germany

14. Maiden name..... Mary Shaeffer  
15. Birthplace..... Belair, Maryland

16. Informant..... Hospital records  
Address..... Catonsville 28, Maryland

17. Date thereof..... 6-7-48  
(Burial, cremation, or removal) (month) (day) (year)  
Cemetery or crematory..... Trinity A.M.E. Church  
Location..... Trinity A.M.E. Church

18. Funeral director..... L. W. Tuerk  
Address..... 136 S. Fort Ave.

19. Date rec'd by registrar..... June 4, 48  
A. W. Hedrich Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 3 19 48 at 7:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 25 19 48 to June 3 19 48 and that I last saw him alive on June 3 19 48

Immediate cause of death..... Arteriosclerotic heart disease DURATION..... indefinite  
Arteriosclerosis, generalized "..... "

Due to.....  
Due to.....

Other conditions..... Aortic aneurysm "..... "  
Arteriosclerotic basis  
(Include pregnancy within 6 months of death)

Major findings of operations.....  
Date of op.....

Autopsy results..... none  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide..... Date of.....  
Where did injury occur?..... (City or town) (County) (State)

Injured at home farm, industry, public place (where?)  
Means of injury..... Injured at work?  
Isadore Tuerk

23. SIGNATURE..... Isadore Tuerk, M.D. M. D. or other  
Address..... Catonsville-28, Md. Date signed..... 6-4-48

MARGIN RESERVED FOR BINDING

9-45-15M

VS-AT-6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5880

44

## 1. PLACE OF DEATH:

County BaltimoreCity or town Fort Howard

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 57 Days

Hospital, institution, or street address where death occurred:

Vets. Adm. Hospital, Ft. Howard, MarylandHow long in hospital or institution? 57 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland

County

City or town Baltimore

(If outside city or town limits, write RURAL and give nearest town)

Street No. 2103 Annapolis Ave.

(If rural, give LOCATION)

2. (a) If veteran, name war WWI

## 3. (a) FULL NAME

ARTHUR J. STRITCH

## 3. (b) Social Security Number

Unknown

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Gertrude Stritch8. (c) If alive, give age 54 years

7. Birth date of

deceased (mo., day, yr.)

12-11-96

8. AGE:

Years

Months

Days

If less than one day

51527

hrs.

min.

9. Birthplace

Baltimore Co. Md.

(Town, county, and State)

10. Usual occupation

Unemployed

11. Industry or business

MOTHER FATHER

12. Name William Stritch13. Birthplace Maryland14. Maiden name Anna Grace15. Birthplace Maryland16. Informant Clinical Records, Vets. Adm. HospitalAddress Fort Howard, Maryland17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

6/15/48

(month) (day) (year)

Cemetery or crematory Baltimore National CemeteryLocation Baltimore, Maryland18. Funeral director Howard N. Blight, Jr.Address 4914 Belair Rd. Balto., Md.

June 14 1948

19

48

A. French

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 11 19 48 at 8:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 15to June 1119 48and that I last saw him alive on June 1119 48

Immediate cause of death

Pulmonary Tuberculosis

DURATION

unknown

Due to

Due to

Other conditions Myocardial infarct, oldCause: Arteriosclerosis

(Include pregnancy within 8 months of death)

unknown

Major findings of operations

Date of op.

Autopsy results substantiated above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

A. French, M.D.

M. D. or other

Address VAH Ft. Howard, Md.Date signed 6-12-48

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

### 1. PLACE OF DEATH:

County Baltimore  
City or town Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months, 24 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 2 months, 24 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 2101 Roslyn Avenue  
(If rural, give LOCATION)  
2. (a) If veteran, name war U.S.

### 3. (a) FULL NAME

Fannie Tinley

### 3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife \_\_\_\_\_ 6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) September 13, 1859

8. AGE: Years 88 Months 9 Days 5 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace England  
(Town, county, and state)

10. Usual occupation Housework None

11. Industry or business Home

12. Name Frederick Tinley

13. Birthplace England

14. Maiden name Mary Spain

15. Birthplace England

16. Informant Hospital records MR. ERNEST HOWARD

Address Catonsville-28, Maryland Ave.

17. Burial BURIAL Date thereof 6/21/48  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory LONDON PARK

Location BALTO. MD.

18. Funeral director Wm. T. TIERNEY & Sons

Address BALTO. MD.

19. June 21, 1948 A. W. Hedrick  
(Date) (d by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 18 19 48 at 1:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 25 19 48 to June 18 19 48

and that I last saw him or alive on June 18 19 48

Immediate cause of death Left lower lobar pneumonia DURATION 48 hours

Due to Hypertensive cardiovascular disease Indefinite

Due to Arteriosclerosis, generalized n.

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Isadore Tuerk, M.D. M. D. or other

Address Catonsville-28, Md. Date signed 6-18-48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Be correct age is especially important. Physicians: please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 32

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Mount Wilson  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 yr., 10 mos., 10 days  
 Hospital, institution, or street address where death occurred: Mt. Wilson  
Branch, Md. T. B. Sanatorium  
 How long in hospital or institution? 1 yr., 10 mos., 10 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County \_\_\_\_\_  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 839 N. Collington Ave.  
 (If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Marie R. Troch

## 3. (b) Social Security Number

None

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife \_\_\_\_\_

## 7. Birth date of

deceased (mo., day, yr.)

April 13, 1921

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

2723

\_\_\_\_\_ hrs.

\_\_\_\_\_ min.

## 9. Birthplace

Baltimore, Maryland

(Town, county, and state)

## 10. Usual occupation

Clerical

## 11. Industry or business \_\_\_\_\_

## FATHER

12. Name Frank J. Troch

## 13. Birthplace

Baltimore, Maryland

## MOTHER

14. Maiden name Mary Stanek

## 15. Birthplace

Baltimore, Maryland

## 16. Informant

Mrs. Mary E. TrochAddress 839 N. Collington Ave., Balto., Md.

## 17. Burial

Date thereof June 19, 1948

(Burial, cremation, or removal. Which?)

(month) (day) (year)

## Cemetery or crematory

Holy Redeemer Cemetery

## Location

4430 Belair Rd., Balto., Md.

## 18. Funeral director

Frank Cvach & Son

## Address

900 N. Chester St., Balto., Md.

## 19. June 16, 1948

(Date rec'd by registrar)

48Walter R. Meyer

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 16, 1948 5:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
August 6, 1946 to June 16, 1948  
 and that I last saw her alive on June 16, 1948

## Immediate cause of death

Pulmonary Tuberculosis

## DURATION

2 yrs.3 mos.

## Due to

Tubercle Bacilli

## Due to \_\_\_\_\_

## Other conditions

None

(Include pregnancy within 3 months of death)

## Major findings of operations

No operation

Date of op. \_\_\_\_\_

## Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

## Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

## 23. SIGNATURE

Stewart S. Shaffer M.D.

M.D. or other

## Address

Mt. Wilson, Md.

Date signed

6/16/48Dr. E. E. Nichols - Prim. 6-19-48

RECEIVED

JUN 21 1948

BUREAU V. 5.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

97

5983

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County.....*Balto.*  
 City or town.....*Sudbrook Park*  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....*Md.* County.....*Balto.*  
 City or town.....*Sudbrook Park*  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....*Cleveland Road*  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex.....*Male* 5. Color or race.....*White* 6. (a) Single, married, widowed, or divorced.....*Married*

6. (b) Name of husband or wife.....*Nancy Holland Tucker*6. (c) If alive, give age.....*69* years

7. Birth date of deceased (mo., day, yr.).....*Sep/29/1870*

8. AGE: Years.....*77* Months.....*9* Days.....*0* If less than one day.....*hr. min.*

9. Birthplace.....*Queen Ann Co. Md.*  
 (Town, county, and state)

10. Usual occupation.....*Lawyer*11. Industry or business.....*Law*

12. Name.....*Alfred Tucker*

13. Birthplace.....*B. A. Co. Md.*

14. Maiden name.....*Susanna C. Atwell*

15. Birthplace.....*B. A. Co. Md.*

16. Informant.....*Nancy H. Tucker - (wife)*

Address.....*Sudbrook Park*

17. Burial.....*Burial* Date thereof.....*July 1-48*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory.....*Chesterfield*

Location.....*Centerville - Rd.*

18. Funeral director.....*Shirley M. Minnick*

Address.....*108 W. York Ave.*

19. *7/1* *25* *1948* *W. H. Hedrick*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*June 29, 1948, at 1<sup>30</sup> P. M.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

*Sept. 11, 1942, to June 29, 1948*

and that I last saw him alive on.....*June 29, 1948*

Immediate cause of death.....*Intestinal Hemorrhage*

(Stomach)  
 DURATION.....*2 wks.?*

Due to.....*arterio-sclerotic*

Due to.....*hypert*

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Manner of injury..... Injured at work?.....

23. SIGNATURE.....*Palmer R. Williams*

Address.....*Pikeville* Date signed.....*Jan 29*



MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 30

5984

124b

## 1. PLACE OF DEATH:

County BALTIMORE  
 City or town CATONSVILLE  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 48 HOURS  
 Hospital, institution, or street address where death occurred:  
HARLEM LODGE SANITARIUM  
 How long in hospital or institution? 48 HOURS

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Md. County Jallott Co.  
 City or town Easton  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Beatrice Broughan Turner

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Harry B. Turner  
 7. Birth date of deceased (mo., day, yr.) Aug 21, 1894 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 53 Months 9 Days 16 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Itasca, N.Y.  
(Town, county, and state)10. Usual occupation home duties

## 11. Industry or business

12. Name Chas. F. Broughan13. Birthplace Itasca N.Y.14. Maiden name Jane15. Birthplace N.Y.16. Informant Harry B. Turner JrAddress Easton Md.17. Burial, cremation, or removal (Which?) Burial Date thereof June 9/48  
(month) (day) (year)Cemetery or crematory Spring Hill CemeteryLocation Easton Md.18. Funeral director John O. Mitchell, SonsAddress 1400 Eutaw Place19. June 8, 48 Q. W. Hester Registrar

(Write rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH JUNE 7 1948 at 11:41 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from JUNE 5 1948 to JUNE 7 1948 and that I last saw him alive on JUNE 7 1948Immediate cause of death CARDIAC FAILURE DURATION 6 HRS.Due to JAUNDICE, OBSTRUCTIVE ? DAYSDue to SEVERE CIRRHOSIS OF THE LIVER ?

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE J. W. Hester M. D. or other \_\_\_\_\_Address 3325 Federal Ave Date signed 6/7/48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

## 1. PLACE OF DEATH:

County Baltimore  
 City or town Rural - Battle Ground - Bear Creek  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County Baltimore

City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1115 N. Bentall  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Benjamin Chandler Ingham

## 3. (b) Social Security Number

216-12-0538

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Myrtle F.

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.)

Jan 21 - 1911

8. AGE:

37

Years

6

Months

7

Days

If less than one day

hrs.min.

9. Birthplace

Ananock, Va.  
(Town, county, and state)

10. Usual occupation

Crane operator

11. Industry or business

FATHER  
MOTHER

12. Name

Jacob Perry Ingham

13. Birthplace

Ananock

14. Maiden name

Emme Russell

15. Birthplace

Ananock

16. Informant

R. A. Burroughs

Address

Ananock, Virginia

17.

(Burial, cremation, or removal, Which?)

Burial

Date thereof

July 1, 1948  
(month) (day) (year)

Cemetery or crematory

Mt. Holly

Location

Ananock, Va.

18. Funeral director

Roland L. Fisher

Address

2112 Dundalk Ave.

19.

Date rec'd by registrar

June 291948W. M. Kelly Jr.

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28 1948 at 7<sup>10</sup> P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on 19 to 19

Immediate cause of death

Drowning

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 6/28/48Where did injury occur? Old Battle Crm - Batt - Md.  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Boat explosion + boat man

Injured at work?

no

23. SIGNATURE

W. M. Kelly Jr. Batt - Md. 6/28/48

Address

Date signed

RECEIVED

JUN 30 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 41

1. PLACE OF DEATH: Baltimore  
 County Baltimore  
 City or town Rural - Old Baltimore - Bentlers  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State Md. County Baltimore  
 City or town Baltimore  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1115 N Bentlers St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Gayle Fox Taylorford

## 3. (b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced S.  
 6.(b) Name of husband or wife  
 7. Birth date of deceased (mo., day, yr.) April 24 - 1938  
 8. AGE: Years 10 Months 1 Days 4 It less than one day  
 .....hrs. ....min.

9. Birthplace Painter 4/4  
 (Town, county, and state)  
 10. Usual occupation Student  
 11. Industry or business  
 12. Name Chandler Taylorford  
 13. Birthplace Anomack  
 14. Maiden name myrtle Fox  
 15. Birthplace Anomack

16. Informant R. A. Burroughs  
 Address Anomack, Va.  
 17. Burial Date thereof July 1, 1948  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Mt. Holly  
 Location Anomack, Va.  
 18. Funeral director Roland E. Fisher  
 Address 2112 Dundalk Ave.  
 19. June 29, 1948 W. M. Kelly Jr.  
 Date rec'd by registrar Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH June 28, 1948 at 6:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 .....19..... to .....19.....  
 and that I last saw him alive on .....19.....

Immediate cause of death Drowning  
 Due to  
 Due to  
 Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations  
 Date of op.

Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: Accidental Date of 6/28/48  
 Accident, suicide, or homicide  
 Where did injury occur Old Baltimore - Bentlers (County) Baltimore (State)  
 Injured at home, farm, industry, public place (where?) Beach Creek  
 Means of injury Boat explosion + man overboard Injured at work? No

23. SIGNATURE M. B. Davis M.D.  
 Address 2112 Dundalk Ave. Date signed 6/29/48

RECEIVED

JUN 30 1948

BUREAU V. S.

RECEIVED

JUN 30 1948

BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

5987  
30

### 1. PLACE OF DEATH:

County..... Baltimore  
City or town..... Catonsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 year, 5 months, 25 days  
Hospital, institution, or street address where death occurred:  
Spring Grove State Hospital  
How long in hospital or institution? 1 year, 5 months, 25 days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County.....  
City or town..... Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 1302 W. Lexington St.  
(If rural, give LOCATION)  
2. (a) If veteran, name war..... ☒

### 3. (a) FULL NAME

Catherine Walsh

### 3. (b) Social Security Number

4. Sex..... female  
5. Color or race..... white  
6. (a) Single, married, widowed, or divorced..... widowed  
6. (b) Name of husband or wife..... John Walsh  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) 1862  
8. AGE: Year..... 86 Month..... Day..... If less than one day..... hrs. min.

9. Birthplace..... Ireland  
(Town, county, and state)  
10. Usual occupation..... housewife  
11. Industry or business..... home  
12. Name..... Michael McGreal  
13. Birthplace..... Ireland  
14. Maiden name..... Margaret McManus  
15. Birthplace..... Ireland

16. Informant..... Hospital records  
Address..... Catonsville 28, Md.  
17. Burial Date thereof..... 6/17/48  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory..... Cathedral  
Location..... Balto. Md.  
18. Funeral director..... William Cook Inc.  
Address..... 1217 St. Paul St.  
19. 6-15-48 Atty. Hedrick  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... June 14 1948 at 1 a. M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
and that I last saw him..... alive on..... 19.....  
Immediate cause of death..... Pneumonia (terminal)  
DUE TO..... cardiovascular disease  
DUE TO..... fracture of right femur  
Other conditions.....  
(Include pregnancy within 3 months of death)  
Major findings of operations..... Date of op.....  
Autopsy results.....  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external cause, fill in the following: June 5, 48  
Accident, suicide, or homicide..... Accident Date of.....  
Where did injury occur?..... hospital Catonsville Balto  
(City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)..... hospital  
Means of injury..... fall from chair Injured at work?..... no  
23. SIGNATURE..... G. Antkiewicz deephled  
M. D. or other.....  
Address..... 1010 Leeds an Date signed..... June 18, 48

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5988

Reg. Dist. No. 34

### 1. PLACE OF DEATH

County Baltimore  
City or town Upperco Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 40 years  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Balto  
City or town Upperco Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. (If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Angelina M. Wilhelmer

### 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced W.  
6. (b) Name of husband or wife Joseph B. Wilhelmer  
7. Birth date of deceased (mo., day, yr.) Oct 18 - 1865 6. (c) If alive, give age years  
8. AGE: Years 82 Months 8 Days 2 If less than one day hrs. min.

9. Birthplace Ind.  
(Town, county, and state)

10. Usual occupation Ref.

11. Industry or business

12. Name George E. Hale

13. Birthplace Ind.

14. Maiden name Wilhelmer

15. Birthplace

16. Informant Rash B. Wilhelmer

Address Upperco Md

17. Burial Date thereof June 23/48  
(Burial, cremation, or removal) (month) (day) (year)

Cemetery or crematory Houston

Location Balto co. Md

18. Funeral director Edw. C. Tipton

Address Hampstead Md

19. 6-22-1948 Mary B. Eline  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 20, 1948 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; I have attended deceased from June 7, 1948 to June 20, 1948

and that I last saw him alive on June 20, 1948

Immediate cause of death Primary Carcinoma of the

of the

Due to

Due to

Other conditions Chronic Nephritis and

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edgar M. Bush

Hampstead Md M. D. 6/20/48

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Give correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 23 1948

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of  
age, shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

5983

730

Reg. Dist. No. 31

## 1. PLACE OF DEATH:

County Balto.  
City or town Phoenix  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 45 yrs.  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County Batts  
City or town Phoenix  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Eli Free Wilhelm

## 3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced Married  
6.(b) Name of husband or wife Mary Francis Wilhelm  
6.(c) If alive, give age 81 years  
7. Birth date of deceased (mo., day, yr.) Oct 13 / 71  
8. AGE: Years 76 Months 7 Days 7 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Ireland Ind.  
(Town, county, and state)  
10. Usual occupation Laborer  
11. Industry or business A.R.  
12. Name Daniel Wilhelm  
13. Birthplace Ind.  
14. Maiden name Eli F. Kirk  
15. Birthplace Ind.

16. Informant Mary F. Wilhelm  
Address Phoenix Ind.  
17. Burial Date thereof 6-23-48  
(Burial, cremation, or removal, which?) (month) (day) (year)  
Cemetery or crematory Cedar Grove  
Location Evans Mc Cormick Rd.  
18. Funeral director Langdon M. Brooks  
Address Sparks, Md.  
19. 6/21 1948 Wm. J. Chilcoat  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 6/20 1948 at 8 A. M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 15 1946 to 6/20 1948  
and that I last saw him alive on 6/19 1948

Immediate cause of death Terminal Anemia  
DURATION 2 yrs.  
Due to Senility  
Due to Arterio sclerosis  
Other conditions \_\_\_\_\_  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_  
Date of op. \_\_\_\_\_  
Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE Wilhelm C. Evans M.D.  
M. D. or other \_\_\_\_\_  
Address Cochranville Ind. Date signed 6/20/48

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JUN 28 1948

BUREAU V. S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 44

5990

**1. PLACE OF DEATH**  
 Baltimore  
 County.....  
 City or town..... Middle River, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 9 years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

**2. USUAL RESIDENCE (HOME) OF DECEASED:**  
 (For newborn infants give residence of mother)  
 State..... Maryland County..... Baltimore  
 City or town..... Middle River, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Black Head Rd.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war.....

**3. (a) FULL NAME**  
 Georgia Wilson

**3. (b) Social Security Number**

**4. Sex** female **5. Color or race** white **6. (a) Single, married, widowed, or divorced** married  
 Samuel E.

**6. (b) Name of husband or wife**  
 Samuel E.

**6. (c) If alive, give age**..... years

**7. Birth date of deceased (mo., day, yr.)** Dec. 26th, 1868

**8. AGE:** Years 79 Months 5 Days 20 If less than one day  
 hrs. min.

**9. Birthplace** Montgomery County, Md.  
 (Town, county, and state)  
 at home

**10. Usual occupation**  
**11. Industry or business**

**FATHER**  
 12. Name..... George W. Dove  
 13. Birthplace..... Montgomery County, Md.

**MOTHER**  
 14. Maiden name..... Mary Wilson  
 15. Birthplace..... Montgomery County, Md.

**16. Informant** Mr. Samuel E. Wilson  
 Address..... Black Head Rd. #202 Route 14

**17. Burial** Date thereof..... 6/18/48  
 (Burial, cremation, or removal, Which?) (month) (day) (year)  
 Cemetery or crematory..... Ebenezer  
 Raspeburg, Md.  
 Location.....

**18. Funeral director** Address..... 7401 Belair Rd.

**19. Date rec'd by registrar** June 17, 1948 John E. Brumby Registrar

**MEDICAL CERTIFICATION**  
**20. DATE OF DEATH** June 16, 1948 2:50 A.M.  
**21. I CERTIFY** that death occurred on the date above stated; that I attended deceased from March 19, 1947, to June 16, 1948, and that I last saw him alive on June 15, 1948.  
**Immediate cause of death** Urterine  
**DURATION**  
 Due to Chorioepithelitis  
 Due to Septicemia  
 Other conditions Puerperal  
 Gestational Sclerosis  
 (Include pregnancy within 3 months of death)  
**Major findings of operations** None  
 Date of op. None  
**Autopsy results** None  
**PHYSICIAN:** Please underline the cause to which death should be charged statistically.  
**22. VIOLENCE:** If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....  
 Where did injury occur?..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?  
**23. SIGNATURE** Joseph L. Leckman, M.D.  
 Address..... 606 Nelson Pt Rd.  
 Date signed..... June 16, 48

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1948

BUREAU V. S.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

5991

Reg. Dist. No. 42

### 1. PLACE OF DEATH:

County Baltimore County

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

River Road

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Baltimore

City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)

Street No. River Road  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Robert H. Young

### 3. (b) Social Security Number

216-14-7276

#### 4. Sex

Male

#### 5. Color or race

White

#### 6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife Alice G. Young

7. Birth date of deceased (mo., day, yr.)

March 12, 1876

6. (c) If alive, give age years

#### 8. AGE:

Years

Months

Days

If less than one day

72

3

5

hrs.

min.

#### 9. Birthplace

Virginia

(Town, county, and state)

#### 10. Usual occupation

Retired Fireman

#### 11. Industry or business

FATHER  
MOTHER

12. Name James I. Young

13. Birthplace Virginia

14. Maiden name Signora Lovell

15. Birthplace Virginia

16. Informant Mr. James R. Young

Address 1342 Linden Avenue, Arbutus

17. Burial  
(Burial, cremation, or removal. Which?)

Date thereof June 30, 1948  
(month) (day) (year)

Cemetery or crematory Grace Cemetery, Elkridge

Location Elkridge, Maryland

18. Funeral director Wm. Cook, Inc.

Address 127 St. Paul Street

19. June 28 19 48  
(Date rec'd by registrar)

Ger Kieffer  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH June 27, 1948 19 48 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 48, fo 19 48

and that I last saw h. alive on 19 48

Immediate cause of death

DURATION

Acute Cardiac failure

Due to

Coronary vascular disease

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ger Kieffer Robert H. Young  
Address 1010 Leed Date signed 6-27-48

**RECEIVED**

JUN 30 1948

**BUREAU V. S.**